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Exploring Weight-Related Attitudes and Experiences

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&

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LIST OF ABBREVIATIONS

BME	Black and Minority Ethnic groups
BMI	Body Mass Index
DOH	Department of Health
EAT	Eating Attitudes Test
GT	Grounded Theory
NCMP	National Child Measurement Programme
ONS	Office for National Statistics
SES	Socioeconomic Status
UK	United Kingdom
USA	United States of America
WHO	World Health Organisation
WMP	Weight Management Programme

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DECLARATION

This thesis has not been submitted for an award at any university other than the universities of Coventry and Warwick and is the candidate's own work.

This thesis was prepared with the assistance of Professor Fiona MacCallum (Academic Supervisor) and Jackie Knibbs (Clinical Supervisor) who commented on drafts of the thesis prior to submission.

Chapter One: The Literature Review 'Attitudes towards weight loss and dieting in ethnic minority groups' was prepared for submission to the International Journal of Obesity (see Appendix 1 for guidelines.)

Chapter Two: Empirical Paper 'Understanding weight-related views and experiences of young people who are overweight' was prepared for submission to the journal of Qualitative Health Research (see Appendix 1 for guidelines).

SUMMARY

The increasing prevalence of people who are overweight and obese is a global health concern, with associated physical health problems that are highly linked to mortality and morbidity. As well as physical health consequences, there are also psychological and social consequences of obesity. The factors that are involved in why excessive amounts of food are being consumed have been explored. Such explanations as to why adults and children are overweight include individual factors as well as social, cultural and environmental influences.

CHAPTER ONE: The literature review critically evaluates the research that has explored the attitudes towards dieting and weight loss of people in ethnic minority groups. The review indicated a number of factors that impact upon individuals ability to manage weight, including individual factors such as the impact on emotional well-being, as well as cultural influences such as tensions around living in two cultures and the dilemma of making different food choices. Clinical implications included tailoring interventions in order to account for individual, family and cultural factors that influence a person's ability to manage their weight.

CHAPTER TWO: The empirical paper aimed to explore weight-related views and opinions of young people who are overweight and were actively engaged within a weight management programme, using a Grounded Theory approach. A model of participants experiences was developed that reflected how participant's sense of self and how they made sense of being overweight were interlinked, and sat within the wider category of how they manage being overweight. Such factors were further influenced by others in the wider systemic context. The findings suggested

implications for tailoring interventions to individuals, as well as exploring the impact of interventions for the family as a whole.

CHAPTER THREE: This paper summarises the reflections of the personal and professional experiences of talking with young people about their weight management journey. The categories within the Grounded Theory model were considered, as were the reflections of doing research with young people.

Chapter One

Literature Review

Attitudes towards weight loss and dieting in ethnic minority groups: A systematic review

Word Count: 5787 (excluding figures, tables and references).

Abstract: 287

Target journal : International Journal of Obesity

1. ABSTRACT

Background and objectives: Obesity is a global public health concern and the prevalence of obesity is growing generally, including within ethnic minority groups. Given the importance of obesity in health status, ethnic differences in obesity are of particular importance. The wider influences on weight gain have been explored, such as culture, socioeconomic status, gender, attitudes and beliefs. This paper aims to review the literature that has explored attitudes towards dieting and weight loss within ethnic minority groups.

Method: Electronic searches were carried out on four databases. Studies were included if they stated the BMI category of the participants, were ethnic minority groups within a Western population and explored or measured attitudes towards weight loss and dieting. 14 studies met the inclusion criteria.

Results: Across the ethnic minority groups explored in these papers (African-American/ South American/ African and Caribbean), several themes were found. Although a tolerance to a larger size was stated, individuals also experienced body dissatisfaction. A significant factor to initiate a diet was to improve physical health. There were tensions around living in two cultures and the dilemma of making different food choices. The obesogenic environment was an important factor that influenced diet and exercise. Being overweight had an impact on well-being, using food as a means of emotion regulation was cited across the studies.

Conclusions: Ethnicity and obesity are multifaceted and 'treating' obesity as a purely physical health problem will not serve to address the whole picture. Future research could look to conduct research in the UK, as there is a high rate of ethnic

minority groups within the population. Clinical implications include tailoring weight loss interventions in order to take into account individual factors such as the impact upon well-being, as well as systemic factors such as family and cultural influences.

Key words: Dieting; Ethnic Minority; Attitudes; Overweight; Systematic
Review

1.1. INTRODUCTION

1.1.1. Overview of Obesity

According to the World Health Organisation (WHO), obesity has nearly doubled worldwide since 1980. Obesity is the fifth leading risk for global death, and more than 10% of the world's adult population was obese in 2008 (WHO, 2013). Since the 1970s, the USA and the UK have had striking increases in the proportion of their populations with a Body Mass Index (BMI) in the overweight and obese ranges (Wang et al., 2011). Being obese increases the risk of physical health problems, including cardiovascular disease, diabetes, musculoskeletal disorders and some cancers (WHO, 2013). Due to such stark statistics, there has been a call for more to be done to manage this obesity epidemic due to the economic, as well as physical health implications of being obese. In the UK, 61.3% of adults are overweight or obese, with England having one of the highest rates of obesity in Europe and the developed world (DOH, 2011).

Obesity and 'overweight' are commonly defined by using the BMI measurement. An individual's BMI is calculated by dividing their weight by their square height in meters (kg/m^2). The classification for overweight is a BMI greater than 25, and for obese, a BMI greater than 30.

1.1.2. Factors involved in the development of Obesity

Essentially, the cause of being overweight is an energy imbalance between calories consumed and the calories expended (WHO, 2013). However, there are thought to be many explanations as to why excessive amounts of food are being consumed. The Foresight Report (Butland et al., 2007) states that being overweight is a

complex interaction of behavioural and societal factors. The report outlines an 'obesity system map' that includes biology, activity environment, physical activity, societal influences, individual psychology, food environment and food consumption.

Such domains highlight the complexity surrounding the notion of becoming overweight, and research has aimed to explore these factors further. A systematic review by Brown and Gould (2011) explored research around decisions about weight management. This was conducted in light of there being interventions for obesity, yet little known about what influenced individuals' initial decisions about weight loss, and reasons for adherence to weight management. The authors proposed a model of themes to consider when supporting an individual to make decisions. Such factors included cultural identity influences, obesity stigma, personal motivators and barriers, social support and practical resources. 'Cultural identity influences' took into account the notion of whether or not a larger body size was problematic, as this would have an influence on making decisions about dieting. The notion of stigma and obesity has been well documented in the literature. In Western societies, there are strong links to negative evaluations of people who are overweight and obese. This may play a role in people presenting to health services, as stigma may be amplified in the thoughts of patients and clinicians (Puhl and Heuer, 2009).

Commonly identified across Brown and Gould's (2011) review were vague motivators such as general attractiveness, and having unrealistic expectations of weight loss attempts. Across studies, they cited that other motivators included

general improvements in quality of life, better physical functioning, and a diagnosed health condition, to name but a few. Barriers for taking action to lose weight included low motivation, knowledge and awareness, and beliefs about the causes of being overweight not being controllable (such as genes).

‘Social support’ included various types of intervention (such as individual and group) and a desire to gain support from health professionals and experts. Family support around decisions to lose weight were more variable, with family seen as a supportive construct by some, but an inhibitor by others. Issues around competitiveness within groups appear to serve as a barrier to losing weight, as did family and social commitments.

Outlined in this review were also the practical resources that support weight management. Most commonly cited were biomedical approaches with focused practical interventions, as these were deemed less stigmatising and disapproving. Pessimism from both individuals who are overweight and clinicians also created an additional barrier to achieving a healthy weight (Kushner 1995). Furthermore, the emphasis on positive health messages rather than weight loss was helpful.

1.1.3. Ethnicity and Obesity

The relationship between ethnicity and obesity is not straightforward. Prevalence rates differ within ethnic groups and there is debate about obesity thresholds, making interpretation of data difficult (Gatineau and Mathrani, 2011). There are disparities in health between ethnic minority and majority groups (Smith, Chaturvedi, Harding, Nazroo and Williams., 2000). Furthermore, there have been numerous studies that demonstrate more prevalence of particular health issues in

ethnic minority groups such as heart disease and diabetes mellitus (Health and Social Care Information Centre, 2004). Given the importance of obesity in health status, ethnic differences in obesity are of particular importance.

There are many other factors that may determine obesity risk within ethnic groups such as food availability, food beliefs, cultural patterns and customs, and level of income (Gilbert and Khokhar, 2008). For example, research looking into rates of dieting behaviour amongst ethnic minority groups, has found that African-American women diet less and have less body dissatisfaction when compared to Caucasian women (Crago, Shisslak, and Estes., 1996; Fitzgibbon Kumanyika, Argurs, Saunders and Morssink., 1998). Social aspects of food consumption were also found to be as important as the food being consumed within African-American culture (Airhihenbuwa et al. 1996). Furthermore, considering physical activity is an important factor in weight management, low exercise levels have been found among Black and South Asian groups in the UK (Rudat, 1994).

Taking into account the above factors, it is not surprising that the initiation of weight loss is challenging, given the complexity of the physical health, psychosocial and cultural influences contributing toward weight gain.

1.1.4. Rationale for this review

Obesity is a global public health concern and the prevalence of obesity is growing generally, including within ethnic minority groups. The relationship between physical health problems and obesity have been explored, however it has also been acknowledged that there are also wider influences on weight-gain, such as culture, socioeconomic status (SES), gender, attitudes and beliefs.

To date, most of the published literature has focused on weight perception and body dissatisfaction (e.g. Roberts, Cash, Feingold and Johnson., 2006). Moreover, there have been no reviews conducted that have explored attitudes toward dieting and weight loss in ethnic minority groups. In drawing together previous literature, the aim is to understand the factors that influence decisions to diet and the ways in which weight is managed. The findings of this review aim to understand the implications of this in order to be able to inform future service provision regarding the management of weight and dieting in ethnic minority groups.

1.1.5. Aims

- To outline and critically evaluate the published research that identifies attitudes and views around weight loss and dieting in different ethnic minorities.
- Identifying the gaps in this literature and discuss what future research can be carried out to address how this information can inform future service provision.

1.2. **METHOD**

1.2.1. Operational definitions

Attitude is defined as a person's way of thinking and feeling about something. In this case, studies looking at a person's perspective, how they think and feel about weight, losing weight and going on a diet, were searched for.

Ethnic minority is defined as 'A group within a community which has different national or cultural traditions from the main population' (Oxford Dictionary). This review aimed to look at ethnic minorities within Western populations.

1.2.2. Inclusion and exclusion criteria

The inclusion criteria used to determine suitability were:

- Studies looking at adults (aged 18 upwards).
- Only peer reviewed articles.
- Ethnic minorities in Western countries.
- Studies looking at body image and weight perception were included if attitudes towards dieting, weight loss, weight management and weight control were also addressed.
- Studies that stated the BMI of participants were included.
- The article was in English.

The exclusion criteria were:

- Studies looking at child and adolescent populations.
- Studies on healthy weight range populations only.
- Studies on people who have undergone bariatric surgery.
- People with eating disorders (e.g. bulimia nervosa and binge eating disorder).

- Studies that also looked at co-morbid health problems (e.g. diabetes, heart disease).
- Studies looking solely at food choices, weight perception, body image, body dissatisfaction.

1.2.3. Search strategy

The search began in November 2013 until February 2014. The databases searched were PsycInfo, Web of Science, Medline and Scopus. All abstracts were considered and full papers retrieved if they met the criteria. All papers were read and searched manually for further potential papers by using the reference lists, as well as looking at the 'cited by' function for further papers. The primary search was performed using the key words 'diet* OR weight loss', 'attitude OR experience', and 'overweight'. A further search adding 'NOT eating disorder' was also used to exclude those studies looking at anorexia, bulimia and binge eating disorder.

See Figure 1. For search strategy.

1.2.4. Assessment of quality

Following the systematic search, the papers were rated for quality using the Caldwell, Henshaw and Taylor (2005) checklist (see Appendix B). This checklist was devised in order to be applied to both qualitative and quantitative research. For example, the quantitative checklist criteria asked 'is the method of data collection valid and reliable', and the qualitative checklist criteria asked 'are the major concepts identified'. For each criterion, a simple 'present / not present' rating was

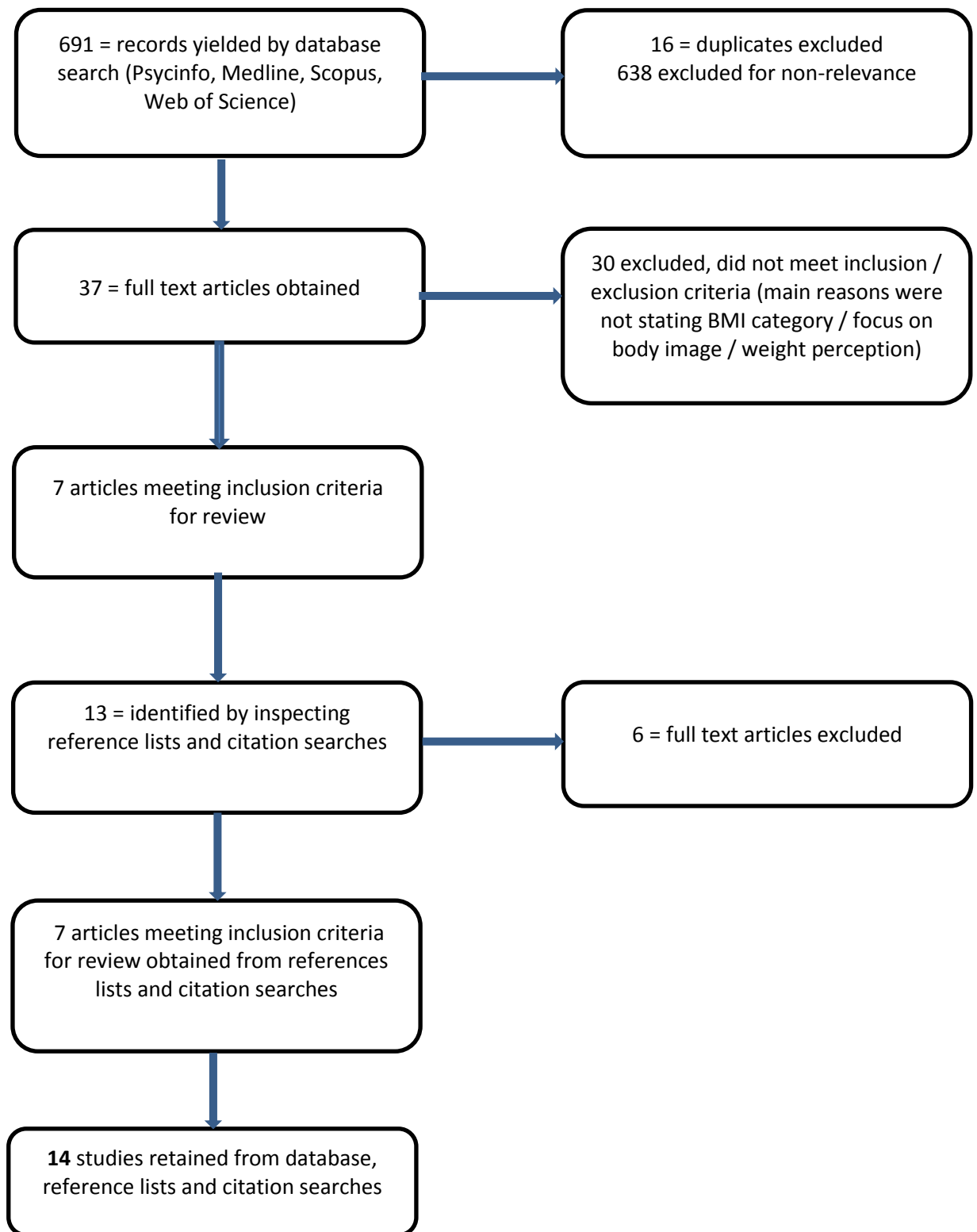


Figure 1. Search strategy

given, with a total score of 18. Using cut off points from authors who used this checklist, papers were given a 'high, medium, or low rating.' All papers were included in this review regardless of quality, although this will be commented upon where relevant.

1.3. RESULTS

The purpose of this review was to identify studies that aimed to explore attitudes towards weight loss and dieting in ethnic minority groups. Attitudes were defined as looking specifically at people's thoughts and feelings around such topics. The 14 papers included in this review include both qualitative and quantitative methodology (see Table 1). The ethnic minorities most researched were Black people (9 studies using African-American participants, and 1 study looking at Black people living in the UK) and South Americans (which is the global term to include Hispanics and Latinos)¹.

1.3.1. Overview of the studies

The findings from these papers will be reviewed in terms of the major themes that emerged from the papers regarding attitudes towards weight loss and dieting. These themes are perceptions of weight and size, family influence, causes and consequences of overweight, reasons for dieting and barriers to weight loss.

¹ Various terminology are used to describe ethnicity, including 'Hispanics' (those from Spanish speaking parts of the Americas) and 'Latinos' (those from South America, the Caribbean and Middle America). Terminology used by authors has been adopted here for ease of reference.

1.3.1.1. Perceptions of weight and size

There is a long held view that those in ethnic minority groups hold more positive attributes to 'fatness' (e.g. Wildes, Emery and Simons., 2001). The views towards larger body sizes were described across eight of the papers being reviewed. However, these papers return varied views and beliefs on this phenomenon.

Some support was demonstrated across ethnic minority groups regarding this idea of a tolerance to larger sizes. For example, in Diaz, Mainous and Pope's (2006) qualitative paper exploring the weight loss experiences of overweight Latinos, male and females voiced the preference for a heavier female body type due to its association with being healthy. An example of this being that if 'you're not fat, you are sick.' Prior to this, Harris and Khoeler (1992) aimed to explore eating and exercise behaviours in Hispanic and Caucasian people and found that Hispanics were less concerned with weight and viewed Americans as being too concerned about weight loss. The acceptance of larger sizes was also evident amongst those studies with African-American participants, whereby women were more likely to be more satisfied with their body and weight (Stevens, Kumanyika & Keil., 1994), less preoccupied with dieting (Kumanyika, Wilson & Guildford-Davenport., 1993) and initiate dieting behaviour later in life, when compared to Caucasian participants (Striegel-Moore, Wilfley, Caldwell, Needham & Brownell., 1994).

Although a tolerance to a larger size was evident, there were also a number of issues raised around being overweight. When considering one's own weight, a number of participants demonstrated dissatisfaction with their weight and self-consciousness at a larger body size (Befort, Thomas, Daley, Rhode & Ahluwalia.,

2008) and had an awareness of being overweight and wanted to be within a healthy weight range (Kumanyika et al., 1993).

Davis, Clark, Carrese, Gary and Cooper (2005) and Blixen, Singh and Thacker (2006) reported that self-image was negatively impacted upon in both African-American and Caucasian participants, who described experiencing a societal pressure to be a thinner shape. Befort et al. (2008) demonstrated a more varied picture, as their African-American participants described an acceptance of a larger body size, and that larger women could be both physically attractive and healthy. Shoneye, Johnson, Steptoe & Wardle (2011) explored black and white British women's attitudes towards weight, and also found that both ethnicities experienced social pressures to be slim. However, whilst this was the case, the Black-Caribbean participants also regarded this issue of slimness to be a 'white weight culture'.

The views around body size and attractiveness was also discussed in conjunction with the notion of a tolerance to a larger shape. The discussion around attractiveness to men arose, with some thinking that a man preferring a larger body shape was a myth, whilst others thought that this was still the case, as expressed by the Black Caribbean participants in Shoneye et al.'s (2011) focus groups. This was also the case in Striegel-Moore et al.'s (1996) quantitative paper exploring weight-related attitudes in dieters. When asked about social pressures about being overweight, Caucasian women reported significantly more negative social pressure about their weight than black women and from a younger age. However, the findings from this study need to be interpreted with some caution as BMI was self-reported and is often underestimated (Gorber, Tremblay, Moher & Gorber., 2007).

Table 1: Selected Papers for Review (alphabetical order)

Author, Year, Country Title	Study Aims	Participant Information (ethnicity / N / demographics available)	Design and Measures	Main findings (re: attitudes)	Limitations	Quality Rating (Low / Med / High)
Agne, A., Daubert, R., Munoz, M., Scarinci, I., & Cherrington, A. (2012), USA The Cultural Context of Obesity: Exploring Perceptions of Obesity and Weight Loss Among Latina Immigrants	Perceptions of obesity and weight management amongst Latina immigrant women.	Mexican immigrants N = 25 women BMI: < 25	<i>Qualitative</i> Focus groups Interview items included: Perceived risk/severity of being overweight; Perceived barriers and benefits of weight loss; Cues to action.	4 themes emerged: Perceptions regarding obesity/ Contributors to weight gain/ Prior weight-loss attempts/ Motivators/programme needs Social isolation, depression, and stress were reported to contribute to weight gain. Participants expressed interest in weight loss but emphasized a desire for programs that preserve traditional foods and include family.	Limitations of focus groups: potential for social desirability Limited generalizability due to small N. Most Ps were Mexican, therefore not generalizable to other Latino sub-groups. Ps were recruited from clinical and non-clinical settings, responses may differ due to health status.	High
Befort, C., Thomas, J., Daley, C., Rhode, P. & Ahluwalia, J. (2008), USA Perceptions and beliefs about body size, weight and weight loss among obese African American women	Explore perceptions and beliefs about body size, weight and weight loss in order to form a design of weight loss interventions with this population.	African American N = 62 BMI: >30	<i>Qualitative</i> 6 Focus groups Interview items included: Beliefs about body size and attractiveness, attributions for weight, reasons to lose weight, social support, experiences with weight loss and treatment preferences.	7 themes emerged: Belief that people can be attractive and healthy at larger sizes /Dissatisfaction with weight and self-conscious about their bodies/ Recognition of eating behaviour as the primary cause for weight gain / Pregnancy, motherhood, and family caregiving as precursors to weight gain / Health and functional status as motivators to lose weight / Mixed social support for weight loss / Preference for lifestyle modification and distrust of medication for weight loss.	Limitations of focus groups: potential for social desirability Large numbers in some focus groups (up to N=16)	High

Blixen, C., Singh, A., & Thacker, H. (2006), USA Values and beliefs about obesity and weight reduction among African American and Caucasian women	Pilot study, aim to gather preliminary data to identify any differences in values and beliefs about obesity and weight reduction, knowledge of obesity-related medical conditions and self-perceived barriers to weight loss.	African American and Caucasian N=20 women BMI > 30	<i>Qualitative</i> 4 focus groups categorised by ethnicity. Interview items included: not outlined.	6 Themes emerged: Attitudes and perceptions of weight / Areas of life affected by weight / Medical knowledge related to obesity / Previous weight-loss attempts / Barriers to successful weight loss / Help from primary care physicians in weight loss effort. African-American women cited culture specific barriers to weight loss.	Limited generalizability due to small N. Limitations of focus groups: potential for social desirability.	High
Davis, E., Clarke, J., Carrese, J., Gary, T., & Cooper, L. (2005), USA Racial and socioeconomic differences in weight-loss experiences of obese women	Examine obese women's experiences of weight loss methods. Focus groups stratified by race and socioeconomic status .	African-American and Caucasian N = 27 women BMI: all women recruited had BMI > 30 (obese range).	<i>Qualitative</i> 4 focus groups, categorised by ethnicity and low/high SES. Interview items included: past and current experiences of weight-loss practices, how weight and SES affected weight-management efforts.	6 Themes emerged: Failure of weight maintenance/ Use of psych and spiritual approaches / Role of family influences and societal expectations / Role of African-American subculture / Method of affordability / Racial differences in weight loss methods.	Limited generalizability due to small N. Limitations of focus groups: potential for social desirability.	Low
Diaz, V., Mainos, A. & Pope, C. (2006), USA Cultural conflicts in the weight loss experience of overweight Latino's	Explore the weight loss experiences and attitudes of overweight Latinos.	Latino (majority Mexican) N = 19 women N = 2 men	<i>Qualitative</i> Focus Groups conducted in Spanish. Interview items included: Experiences of weight loss, what makes it difficult to lose weight, experiences of weight loss advice.	5 Themes emerged: Mixed messages when determining one's appropriate weight Discordance when adapting into the mainstream Familiarity with weight loss methods and failed weight loss attempts Expectation of weight assessment and counselling from health-care providers Importance of interactions with peers during education.	Limited generalizability due to small N. Limitations of focus groups: potential for social desirability.	Med

<i>Harris, M & Khoeler, K. (1992), USA</i> Eating and exercise behaviors and attitudes of Southwestern Anglos and Hispanics	Investigate cultural differences in attitudes and behaviours related to eating, exercise and Weight and nutrition.	Hispanic and Caucasian N= 173 men N = 145 women BMI: Self-reported	<i>Quantitative</i> Eating and Exercise Behaviour Questionnaire (Brandon, 1998). Attitudes about Weight Questionnaire (Stern et al., 1982). Weight-Control Beliefs (Sims, 1978).	Caucasians indicated that they exercised more than Hispanics, felt they had more in the ability to control their weight through exercise and other means. Hispanics thought that Americans were too concerned about weight. Knew less about weight control and showed less interest in nutrition.	Attitudinal and behavioural measures had not been widely used, poor reliability and validity.	Med
<i>Kumanyika, S, Wilson, J, Guildford-Davenport, M. (1993), USA</i> Weight-related attitudes and behaviors of black women	To assess weight-related attitudes and practices of women who attended health dept clinics.	African American N = 500 women Age range: 25-64 BMI: 15.1 – 60.4	Quantitative Self-administered 50-item Questionnaire incl. Demographic, medical, reproductive and life-style variable, weight-related attitudes and behaviours. *sources not cited	Overweight women less satisfied with their weight and more likely to have dieted. Relatively positive body image. Overweight women were less likely to exercise Of those who had previously dieted, overweight women were more likely to have regained all the weight lost.	Weight was self-reported and potentially inaccurate, as there is a tendency to underestimate / underreport weight Limited generalizability as Ps recruited from a health clinic. Psychometric properties of measures not stated, reliability and validity unknown.	Med
<i>Lynch, C., Chang, J., & Ford, I. (2007), USA</i> Obese African-American Women's Perspectives on Weight Loss and Bariatric Surgery	Explore perceptions of obese AA women and describe factors that represent barriers to their weight loss in general, and use of bariatric surgery in particular.	African American N = 41 BMI: >30	<i>Qualitative</i> 6 Focus Groups	Focusing on barriers to weight loss: 3 themes emerged: Lack of time and access to resources / Issues regarding control (intrinsic and extrinsic) / Identification with a larger body size.	Limited generalizability due to small N. Limitations of focus groups: potential for social desirability.	High
<i>Martinez, J., Powell, P., Agne, A., Scarinci, I. & Cherrington, A. (2012), USA</i> Focus group study of Mexican immigrant men's perception of weight and lifestyle	Explore Mexican immigrant men's perspectives regarding weight, diet, and physical activity as they relate to the individual and the family.	Mexican immigrants N = 16 men BMI: mean 28.4	<i>Qualitative</i> 3 Focus groups Interview items included: Meaning of being a healthy weight; thoughts on being overweight; attempts at weight loss; physical activity and barriers.	4 Themes emerged: Perceptions of weight, diet, and physical activity / Perceived barriers to healthy living/ Social structure, policy, and systems / Perceived facilitators to healthy living.	Ps were Mexican, therefore not generalizable to other Latino sub-groups. P's were from the same community, some knew each other. Impact on emerging discussions and subsequent themes.	High

<p><i>Mastin, T & Campo, S. & Askelson, N. (2012), USA</i></p> <p>African American Women and Weight Loss: Disregarding Environmental Challenges</p>	<p>Explore African-American's views of Knowledge about health issues, weight loss self-efficacy, outcomes of weight loss, and obstacles that influence obesity.</p>	<p>African-American N = 46 women BMI: < 30</p>	<p><i>Mixed methods</i></p> <p>Structured interviews and questionnaires</p> <p>Measures included: Perceived weight loss efficacy (Clarke et al., 1991); Perceived Facilitators (Felton et al., 2002).</p>	<p>Lack of knowledge regarding healthy food choices and the benefits of exercising. Low self-efficacy regarding weight-loss, little support from family and friends, comfort eating expressed, environmental factors such as financial challenges and physical environmental challenge.</p>	<p>Psychometric properties of measures not stated, reliability and validity unknown.</p> <p>Limited generalizability as P's recruited from a specific geographical area.</p>	<p>Med</p>
<p><i>Shoneye, C., Johnson, F., Steptoe, A. & Wardle, J. (2011), UK</i></p> <p>A qualitative analysis of black and white British women's attitudes to weight and weight control</p>	<p>Aimed to explore attitudes towards weight and weight control among black and white British women.</p>	<p>Black Caribbean/African and Caucasian N= 25 Caucasian N= 24 Black Caribbean / African</p>	<p><i>Qualitative</i></p> <p>7 focus groups, categorised by ethnicity.</p> <p>Interview items included: Beliefs about weight and overweight, food preferences and dietary choices, barriers and facilitators to weight loss, physical activity and weight control approaches.</p>	<p>5 themes emerged: Terminology and classification of weight / Attitudes towards being overweight / Social pressures / Catalysts for lifestyle change</p> <p>All Ps had a fairly good knowledge of causes, consequences and treatment of being overweight.</p> <p>Black women emphasised health consequences of being overweight, whilst White women were more likely to focus on social and emotional consequences.</p> <p>White women associated overweight with negative character traits whereas Black women had a broadly positive attitude towards larger sizes.</p>	<p>Limitations of focus groups: potential for social desirability</p> <p>Limited generalizability due to small N.</p> <p>Black and white Ps were not taken from the same communities</p> <p>Sample were well educated, difficult to generalise findings to other SES groups.</p>	<p>High</p>
<p><i>Sira, N & Pawlack, R (2010), USA</i></p> <p>Prevalence of overweight and obesity, and dieting attitudes among Caucasian and African American college students in Eastern North Carolina: A cross-sectional Survey</p>	<p>Assess dieting attitudes among college students by gender and ethnicity; and assess whether there was a statistically significant difference in dieting behaviour by gender and ethnic background.</p>	<p>African-American and Caucasian College Students Aged 18-25 N = 526</p>	<p><i>Quantitative</i></p> <p>Measures: Eating Attitudes Test (EAT-26), assesses a broad range of symptoms of anorexia/bulimia nervosa, dieting and food preoccupation.</p>	<p>The rate of BMI≥25 differed by gender and ethnicity, with males and African Americans having higher rates.</p> <p>Results support the generally held belief that disturbed eating attitudes and unhealthy dieting are common.</p>	<p>Subscales of EAT-26 were not analysed.</p> <p>African-American Sample was small, especially for males (N= 14), results not generalizable due to small sample size and college students.</p>	<p>Med</p>

<p><i>Stevens, J, Kumanyika, S & Keil, J. (1994), USA</i></p> <p>Attitudes toward body size and dieting: differences between elderly black and white women</p>	<p>Examine attitudes towards eating and body size perception in elderly black and white women.</p>	<p>African-American and Caucasian N= 278 Caucasian women N = 126 African American women Age: mean 73 years</p>	<p><i>Quantitative</i></p> <p>Measure developed to assess Eating Restraint and Body Image.</p>	<p>Overweight African-America women less likely to feel guilty after overeating, less likely to diet, more likely to be satisfied with their weight and consider themselves attractive.</p> <p>Of those who were not overweight, African-American women were half as likely to consider themselves as overweight.</p>	<p>Poor reliability and validity. Generalisability: elderly sample, study conducted 20 years ago.</p>	<p>Low</p>
<p><i>Striegel-Moore, R., Wilfley. D., Caldwell, M., Needham, M. & Brownell, K. (1996). USA</i></p> <p>Weight-related attitudes and behaviours of women who diet to lose weight: a comparison of black dieters and white dieters</p>	<p>Examine differences in attitudes and beliefs about dieting, motivations underlying dieting efforts, and actual dieting strategies and behaviours.</p>	<p>African-American and Caucasian women N = 162 (African-American) N = 162 (Caucasian) BMI: Self-reported, not stated. Age: Not stated</p>	<p><i>Quantitative</i></p> <p>Data taken from Wave 2 of a larger scale study.</p> <p>Questionnaire measures: Social Pressures about overweight, and Personal Attitude and Beliefs about Thinness/ Reasons for Dieting.</p>	<p>African-American women experienced less social pressure about their weight, initiated dieting later in life and significantly less likely to diet at each developmental milestone.</p> <p>African-American and Caucasian women did not differ in weight loss strategies, or reasons for most recent dieting attempt, coping with dietary relapse or rates of disordered eating.</p>	<p>Weight was self-reported and potentially inaccurate, as there is a tendency to underestimate / underreport weight Psychometric properties of measures not stated, reliability and validity unknown.</p>	<p>Med</p>

Furthermore, this article was written 18 years ago and may be less relevant to women today.

Stevens et al. (1994) explored attitudes toward body size and dieting in elderly black and white women, and found that black women were more likely to consider themselves attractive regardless of their current weight status, were generally more satisfied with their body than white women, and were 2.5 times more likely to be satisfied with their weight. This therefore gives further support to the notion of black women being more satisfied at a larger size. However this study is a cross-section of elderly women in research conducted 20 years ago, and so such findings must be interpreted with caution considering the growing influence of Western ideals globally.

1.3.1.2. Family influence

All but one qualitative paper cited the influence of the family regarding weight and weight loss. Quantitative papers did not measure the impact of the family context on weight loss so will not be included here.

Within the qualitative literature, some papers described participants attributing causes of weight gain, as well as barriers to weight loss, to the wider family context. For example, Martinez, Powell, Agne, Scarinci and Cherrington's (2012) paper conducted a focus group exploring men's (Mexican immigrant) perceptions of weight and lifestyle, and found that men perceived women to be the 'nutritional gatekeeper of the home,' and commented on the etiquette around not declining the meals that have been prepared. Both Diaz et al. (2006) and Agne, Daubert,

Munoz, Scarinci and Cherrington (2012), where participants were majority Latino females, also described needing the family to 'buy-in' for weight loss (Agne et al., 2012) as the family could be difficult and uncooperative when trying to diet (Diaz et al., 2006). This was echoed in the African-American groups, whereby participants' family gatherings and social eating were an important aspect of African-American culture, and traditionally fried foods would be served. Participants in the papers focusing on African-American groups spoke of finding it difficult to make changes to food preparation as this wouldn't be accepted by the wider family (Befort et al., 2008; Blixen et al., 2006 and Lynch, Change, Ford & Ibrahim., 2007). Mastin, Campo and Askelson (2012) used both questionnaire and interview to ascertain weight loss thoughts and perceived obstacles for African-American women, using a social cognitive theory framework. Both quantitative measures (rating helpfulness of various potential support) and qualitative enquiry suggested that these African-American women perceived little support from friends or family, and commented that family members were perhaps not supportive and other family priorities would take over. The study recruited participants from one geographical location and therefore generalisability is limited.

Lynch et al. (2007) suggested a theme regarding 'identification with a larger body size', which described how the African-American participants in their study felt a sense of belonging when mirroring the appearance of family members, who tended to be larger. Furthermore, they described how relationships with friends changed after weight loss, as friends became competitive and less supportive. Befort et al. (2008) also found that family support was experienced by some participants, mainly

by family being accepting regardless of body size, or simply not making comments about weight. Such factors are important considerations given the above studies, suggesting the role of having positive involvement from the wider family when losing weight was influential.

1.3.1.4. Causes and consequences of being overweight

There were a number of factors identified regarding the causes and consequences of being overweight.

The emotional impact of being overweight or gaining weight was commented upon by both males and females and across all ethnicities (Lynch et al., 2007; Agne et al., 2012 and Martinez et al., 2012).

In Agne et al.'s (2012) study, participants discussed the emotional impact of moving from South America to the USA, and described the cyclical process of feeling depressed due to being isolated, and using eating as a coping mechanism. Emotional eating was also raised by Lynch et al.'s (2007) African-American women, who felt that eating helped them to deal with emotional and psychological stressors. Men also discussed similar concepts within the context of the disadvantages of weight gain. These factors involved depression, lowered self-esteem and social rejection (Martinez et al. 2012).

Kumanyika et al. (1993) suggest that dieting patterns and behaviours are similar in both African-American and Caucasian women. Sira and Pawlak (2010) investigated dieting attitudes in Caucasian and African-American college students using the Eating Attitudes Test (EAT-26; Garner et al., 1982) and aimed to assess statistical

significance in dieting behaviour by ethnicity. They found that there were no significant differences between the rates of disturbed eating between the 2 groups. The authors therefore suggest that this may reflect more similarity regarding body perception and attitudes towards weight. However, this study is limited as the authors did not explore the EAT-26 in terms of its subscales. Of particular interest regarding attitudes, would have been the 'dieting' and 'food preoccupation' subscales. Also, this study focused on college students and therefore any interpretations made would need to be considered with caution.

1.3.1.5. Reasons for dieting

The main reason cited for wanting to lose weight were health reasons, with participants demonstrating an awareness of co-morbid health problems of being overweight (Kumanyika et al., 1993 and Befort et al., 2008).

Befort et al.'s (2008) qualitative study focusing on African-Americans only, found that participants had unanimously reported that their number one reason for weight loss was for health reasons. Many had other health conditions such as heart disease, diabetes and chronic pain, and had been advised to lose weight by a physician. For those that did not have health conditions, they were aware of a family history of health problems and therefore wanted to take preventative measures for developing such conditions. The health related focus for losing weight was also found in Blixen et al. (2006) and Diaz et al. (2006). Blixen's study involved both African-American and Caucasian participants, and found that both ethnicities cited medical problems as directly being associated with their weight.

Health was not cited as the most motivating factor for weight loss in all cases however. Often cited were 'feeling good' and improving appearance (Agne et al. 2012, Kumanyika et al. 1993). Striegel-Moore et al. (1996) showed that there were no significant differences between African-American and Caucasian participants in their reasons for wanting to lose weight, both rating 'appearance' and 'feeling better about themselves' as the most important reasons. Furthermore, Blixen et al. (2006) found that whilst appearance was important when younger, health-related concerns became the more prominent factor when older.

1.3.1.6. Barriers to weight-loss

It is important to understand what obstacles might be present for people who may want to lose weight. The most commonly cited reasons related to factors regarding the obesogenic environment were food availability and affordability, as well as the physical environment. Furthermore, the tensions around living within two cultural contexts were also raised.

Food affordability and availability

Davis et al. (2005) explored racial and socioeconomic differences in weight-loss experiences of obese women, and found that all groups (black, white, high and low SES) expressed concern regarding the cost of healthy food in comparison to less healthy options. However, lower SES groups felt that affordability limited their weight management efforts and a desire to lose weight. Both Mastin et al. (2012) and Lynch et al. (2007) asked participants about barriers to weight loss following a healthy diet. Similarly to Davis et al.'s (2005) findings, these women listed

affordability of healthy foods, attending weight loss programmes and costly gym memberships, as well as highlighting a lack of insurance coverage for non-surgical weight management options as barriers (Lynch et al., 2007).

Across the three qualitative studies (Diaz et al., 2006; Martinez et al., 2012 and Agne et al., 2012) with the Latino/Hispanic populations, the transition from South America to the USA also came with some challenges. Specific dietary changes included a decrease in the consumption of fresh fruit and vegetables, the 'fast food' culture with an emphasis on quick and convenient food, and the general accessibility of food being greater in the USA than in their native countries (predominantly Mexico). Similarly, Davis et al. (2005) returned findings that the American culture of a sedentary lifestyle, excessive food availability and media influences appeared to make weight loss a challenge for both ethnic groups (black and white), as well as SES groups within their study.

Furthermore, the research found that living within two cultures also caused tension at times with regards to dieting. For example, African-American women highlighted that in particular settings (such as Church), food types and food preparation (such as greasy food), and the expectancy of an abundance of food, impacted upon the ability to diet (Davis et al., 2005; Blixen et al., 2006 and Shoneye et al., 2011)

Physical environment

The physical environment was also an important factor regarding barriers to weight loss. For the South American participants, they noticed that there had been a reduction in physical activity. They cited that environmental factors such as a 'lack

of sidewalks' hindered the ability to go for walks and necessitated the use of a car to travel (Agne et al., 2012 and Martinez et al., 2012). This notion was also raised by those who had not transitioned from one country to another, such as participants in Shoneye et al.'s (2011) study where both ethnicities (black and white) also described the features of an obesogenic environment as being barriers to weight loss, such as using a car and the home comforts that encourage people sit down.

A further barrier to weight loss regarded the lack of personal safety to do exercise in the local neighbourhood (Mastin et al., 2012 and Martinez et al., 2012) as well as perceived discrimination for being out and walking alone (Martinez et al. 2012).

1.4. DISCUSSION

1.4.1. Summary of findings

The findings demonstrate that the ethnic minority groups focused upon in this review may have a more tolerant attitude towards a larger body size. However this tolerance to a heavier size is not a straight forward one. Although there might be a tolerance towards a heavier shape, societal pressure to be slim is still experienced, with this having an impact upon the individual who is overweight, although perhaps less so than seen in Caucasian individuals. The reasons for wanting to lose weight seem to go beyond attractiveness and societal pressure however, with more focus upon improving physical health. Whilst the positive appraisal of a larger shape may serve as a protective factor against societal pressures to be slim and the impact

upon self-esteem and body dissatisfaction, it may also undermine people's motivation to lose weight should they not fall within a healthy weight range.

Across all groups, family support and influence was considered to be a key factor in people being able to lose weight. Concern was raised regarding not compromising traditional cultural practices whilst making changes to their diet. Furthermore, a 'whole family approach' seemed to be important in supporting people to lose weight.

The psychological impact of gaining weight, being overweight and trying to diet was an important concept that participants across studies cited as a barrier to losing weight. The interaction of managing emotions and being overweight are multifaceted; isolation, the transition to a new culture, and dealing with other life stressors were all a part of this process. The cues to initiating a diet were mainly to improve physical health, but also more vague concepts around 'feeling good' and improving appearance. As in Brown and Gould's review (2011), the latter reasons for dieting were shown to be less successful in being able to maintain dieting. Finally, the obesogenic environment was cited as another barrier to losing weight, and a well-documented challenge in the quest to achieve a healthy body weight.

1.4.2. Methodological Limitations

There are some general limitations regarding both the qualitative and quantitative aspects of the reviewed papers that are important to acknowledge when considering the above findings. The papers reviewed included 7 rated as 'High'

quality, 5 as 'Medium' and 2 as 'Low' quality articles, and the following limitations are relevant to the low and medium rated papers.

All but one qualitative paper used focus groups to collect their data. This is an effective and efficient method of data collection that is flexible, inasmuch as groups can be used as a stand-alone qualitative method or combined with quantitative techniques. However, individuals may be influenced or biased by others' views or opinions within a group, and there may be a sense of social desirability emerging from the group dynamics and therefore a full range and complexity of participants' opinions may not be elicited (Carey, 1995). Focus groups varied in size, with some studies having focus groups with more than ten participants (e.g. Befort et al., 2008). The above factors may be more pertinent in larger group sizes, and if more dominant group members were not managed effectively, this could have an impact on the overall findings. As with all qualitative research, the generalisability of findings is limited due to numbers of participants.

The five quantitative papers aimed to measure various aspects of weight-related attitudes in minority groups. Limitations were evident in descriptions of the measures, as only Sira et al. (2010) described the psychometric properties of the EAT-26. Other papers did not state such properties, and therefore results should be regarded with caution as the reliability and validity are unknown. Where they were reported, such as in both Harris & Koehler (1992) and Stevens et al. (1994), test re-test reliability was low. It would have been beneficial for authors to have stated the effect size in addition to the significance, particularly as some papers had a large

number of participants', this would have added value to the interpretation of findings.

1.4.3. Limitations

The selected studies were limited to English language only. As the review focused upon ethnic minorities within Western populations, this seemed appropriate, but of course some key papers could have been omitted. Many of the Latino / Hispanic articles described translating their information into Spanish in order to aid recruitment, and so it could be possible that articles written in Spanish may have been missed. Furthermore, papers were excluded that explored attitudes towards dieting and weight in different countries because they were not focusing upon the ethnic minority groups within that country.

Only one study focused upon the views and attitudes of men, therefore this review and the research included holds a bias towards women that must be acknowledged.

In order to be systematic, a definition of 'attitude' needed to be applied in order to be able to identify the papers for review. In searching for the literature, there were many different interpretations of what constituted attitudes. It is possible that other literature may have been missed due to a lack of consistency in definition.

1.4.4. Suggestions for future research

As is evident in the presented research, the literature exploring attitudes towards weight loss has been predominantly conducted in America. There have been some important findings regarding this, and such conclusions will be able to inform future service provision for those ethnic minority groups. What is surprising is the lack of

research conducted within the UK, with only one paper being found to have addressed this. According to the Office for National Statistics (ONS), in England and Wales, Asian/Asian British group accounts for 7.5% of the population and Black/African /Caribbean/ Black British group accounts for 3.3% (Office for National Statistics, 2011). It is well documented for example, that Asian, African and Caribbean groups are likely to suffer from both cardiovascular diseases, as well as developing diabetes, which is often exacerbated by being overweight. It may therefore be helpful to explore further the views of ethnic minority groups in Britain regarding obesity, dieting and weight loss in order to tailor advice and weight loss programmes to ensure they are suitable, appropriate and helpful for the target audience.

Women comprised the majority of the participants across the studies reviewed in this literature review, and it may therefore be helpful for future research to explore men's attitudes towards weight loss. Although there may be less pressure for men to be slim, there is an increasing trend for men to have a certain body shape, and this may have adverse effects on how men achieve this.

1.4.5. Clinical Implications

There is a general finding that a larger body size may be more accepted in the specific ethnic minority groups discussed in this review when compared to the Caucasian population. The research reviewed also found that those individuals from ethnic minorities who are in the healthy weight range are more satisfied with their weight when compared to Caucasian individuals, as well as being more concerned about the impact upon their health. Therefore a focus on the health

implications of obesity, rather than on dieting, and tailoring interventions to consider dietary changes that are acceptable and manageable within different cultures would seem appropriate. There needs to be a balanced approach towards encouraging health and promoting the health benefits of being within a 'normal' weight range without undermining people's healthy attitudes towards their shape and size.

It was also found that being overweight did indeed have an impact upon emotional well-being for some, and it therefore must not be assumed that all individuals within an ethnic minority group are not emotionally affected by being overweight. Health professionals need to be aware of making assumptions that all individuals within a particular ethnic minority group are 'happy' to be overweight, as there is the potential to overlook important processes, such as using food as a means of emotion regulation.

Another important finding from this review was regarding the impact that family 'sub culture' has on an individual's ability to make changes to their diet and exercise routine. Wider implications involve health promotion strategies regarding the impact of a healthy diet on physical health at a community level. Tailoring the information given in order for it to be meaningful and relevant to particular groups would be helpful, for example where there are higher prevalence rates of particular physical health conditions in ethnic minority populations. Health promotion strategies considering the needs of ethnic minority groups within the child population have begun to be addressed within the 'Change4Life' government

strategy within the UK, but as yet, this has not been considered within the adult population.

1.5. CONCLUSIONS

Ethnicity and obesity are multifaceted and 'treating' obesity as a purely physical health problem will not serve to address the whole picture. This review has highlighted particular attitudes around the individual and systemic influences involved in being a heavier weight, and suggestions for future research and clinical implications are outlined with those factors being taken into account.

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Chapter Two

Empirical Paper

Understanding weight-related views and experiences of young people who are overweight

Word count: 8393 (excluding figures, quotes and references)

Abstract: 148

Target Journal: Qualitative Health Research

2. ABSTRACT

Obesity is an increasing concern for young people yet there has been little research that has attempted to ask young people their views on being overweight, and ascertain the support they think they might need to achieve a healthy weight. This study interviewed 11 young people who were attending a weight management programme to explore this further. Using a Grounded Theory approach, a model of the participant's experiences was developed. The core categories reflected how participant's sense of self and how they made sense of being overweight were interlinked, and sit within the wider category of how they manage being overweight. Such experiences sit within the wider systemic context. Clinical implications suggest the inclusion of addressing the emotional aspects of being overweight as well as tailoring interventions to meet individual's needs. Future research would be beneficial in the area of understanding interventions for the family as a whole.

Keywords: Grounded Theory; Young Person; Overweight; Weight Management; Experience

2.1. INTRODUCTION

Obesity is becoming the epidemic of our time. Obesity and being overweight represent a widespread threat to health and wellbeing in this country. According to the findings from the National Child Measurement Programme (NCMP), 23% of adults are obese, 33.3% of 10-11 year olds are obese or overweight, and 23.5% of 4-5 year olds are overweight or obese. Although it appears that obesity in children is levelling off, the overall level of obesity is high, and England ranks as one of the most obese nations in Europe (Department of Health [DoH], 2011).

Much research has been undertaken into understanding the physical health consequences of obesity and the potential trajectory of costs to the National Health Service (NHS). The Department of Health's initiative for tackling obesity is outlined in 'Healthy Lives Healthy People; A call to action on obesity in England.' This paper outlines its aims to achieve a sustained downward trend in the level of excess weight in children as well as adults by 2020. The DoH outlines the need to adopt a 'life course approach' by tackling obesity with effective prevention, treatment and support opportunities. As well as the impact upon the economy in terms of physical health implications, it has also been recognised that obesity has a significant impact on self-esteem and quality of life.

In aiming to tackle obesity, the main priority has been to slow down the rate of weight gain and then to reverse it. Prevention is important, given the burden of disease from adult obesity. The associated health risks include being five times

more likely to develop type II diabetes for men, and almost thirteen times more likely for women, men being three times more likely to develop cancer of the colon, as well as at greater risk for high blood pressure which is a risk factor for stroke and heart disease. Furthermore, overweight women are three times more likely to have a heart attack and also develop high blood pressure (DoH, 2011).

Considering the knowledge we have of the significant physical impact alone of overweight and obesity on the adult population, preventing obesity has therefore become key when considering managing overweight in children and adolescents. With government marketing strategies to reduce weight such as 'Change 4 Life', a health promotion campaign to reduce obesity levels in children under 11 by implementing a behaviour-change model for obesity, gaining insight about how choices are made and behaviours are acquired is essential for preventing childhood obesity (Lopez-Dicastillo, Grande and Callery, 2010).

Whilst there is a focus on the physical impact of obesity, it is generally not regarded as a psychological disorder. Some researchers and clinicians do however make an argument for obesity to be regarded as a mental or behavioural issue (Cornette, 2011). Russell-Mayhew, McVey, Bardick and Ireland (2012) conducted a systematic review of the current evidence of the association between mental health and childhood obesity. They argue that most efforts to 'reverse the obesity epidemic' have focused solely on nutrition or food intake and increasing physical activity, and that understanding how obesity and mental health may be linked has been overlooked. Their model outlines how overweight / obesity impact upon and are a

result of psychosocial health (depression, anxiety, self-esteem) and wellness (quality of life, protective factors), and how mediating variables (weight-based teasing, concern about weight and shape) may influence this.

In reviewing literature in the area of depression, there are mixed findings, as depression may be both a cause and a consequence of obesity (Goldfield et al. 2010). When reviewing the anxiety literature, some studies showed a higher lifetime prevalence of anxiety disorders in obese adolescents compared to non-obese controls (Britz et al. 2000) yet other research demonstrated no significant relationship between increased BMI and anxiety symptoms (Tanofsky-Kraff et al., 2004). When considering psychosocial mediating variables, it has been proposed 'intervening for the psychosocial emotional health of overweight / obese children should be a focus in and of itself and not just an 'add-on' measure to a primary outcome that is targeting weight reduction or the cessation of weight gain' (Russell-Mayhew et al. 2012, p6).

Another avenue to understanding the difficulties that may arise in attempting to prevent, manage and 'treat' overweight and obesity, has been to seek out the experiences and opinions of those involved within the process, namely healthcare professionals, those in education, parents and at times, the children themselves. Story et al. (2002) investigated the attitudes, barriers, skills and training needs amongst health care professionals in the management of child and adolescent obesity. They found that the most frequent barriers were lack of parent involvement, limited individual motivation and lack of support services. It was also

highlighted that the professionals in this study expressed low proficiency in the use of behavioural management strategies, guidance in parenting techniques and addressing family conflict, as well as a low confidence in their ability to change behaviours. The limitation of this study however was the low response rate of professionals, and thus the conclusions cannot be easily generalised. Limited perceived proficiency in areas such as counselling skills was also found in Barlow and Dietz's (2002) summary of reports from health care professionals. They found that barriers to effective treatment of obesity in children included a lack of time available for counselling and patient motivation.

In considering the prevention of obesity, Dietz (1994) identified that infancy and adolescence were two of the three critical periods in the development of obesity. There has therefore been a focus on understanding the home environment and the influence of parents as being key to facilitate behaviour change. Lopez-Dicastillo et al. (2010) investigated parents' perceptions of food and activity choices and found that parents' concerns about under-consumption of food and over-activity contrast with the public health priorities to reduce intake and promote exercise. Furthermore, Hesketh, Waters, Green, Salmon and Williams (2005) found that parents expressed beliefs and described behaviours around healthy eating that are at odds with obesity prevention strategies, such as daily treats being acceptable. However, both studies report limitations in being able to recruit participants from diverse backgrounds with respect to ethnicity and socio-economic status, and therefore the findings will not be fully representative of a general population of parents.

Generally, the opinions of children regarding the topic of being overweight have been somewhat overlooked. A systematic review of the views of young children in the UK about obesity, body size, shape and weight was undertaken by Rees, Oliver, Woodman & Thomas (2011). Rees et al. pooled together both quantitative and qualitative research of perspectives of children aged 4-11, and reported on 28 studies. Rees et al. found that during their search for research that included the opinions and beliefs of children, they 'found no studies that asked children directly what they thought should be done to help them to reach or maintain a healthy size' (p4.). They also highlighted that only 3 studies aimed to study children with a high body size (Edmunds, 2000; Murtagh, Dixey and Rudolph, 2006 and Walsh-Pierce & Wardle, 1997) and concluded that new initiatives needed to consider the social aspects of obesity and that children should be involved in understanding appropriate forms of support around this issue.

Murtagh et al. (2006) conducted a qualitative study that aimed to investigate the levers and barriers to weight loss in children with obesity. The themes that they explored included: reasons for change, cues for action, barriers to action, continued compliance and barriers to compliance. The results from their study highlighted how a main drive for these children to want to lose weight was due to feelings of exclusion and experiencing bullying. Having the support of an external figure helped a child to initiate and sustain their efforts to lose weight. Barriers to making change were felt to be due to delayed parental recognition, previous negative experiences of weight loss attempts, and behavioural sacrifice. Barriers to weight loss maintenance included short comings in individuals' physical abilities, the time

taken to lose weight, and external factors beyond their control. Walsh-Pierce and Wardle (1997) explored the cause and effect beliefs of self-esteem of overweight children using both qualitative and quantitative methods. They concluded that lower self-esteem was found in those children who felt responsible for their weight and believed that it hindered their interactions with others. They had interviewed children and outlined their approach to minimising potential distress and embarrassment to the child, however they did not tape record interviews and relied on the interviewer's notes. A limitation therefore is the potential for there to have been interviewer bias in reporting the interviews.

2.1.1. Rationale for current research

There is a lot of discussion around the notion of seeking the opinions of children in many areas of research, such as understanding their own notions of health and well-being, as well as being part of the research process. Darbyshire et al. (2005) discuss that 'the predominant approach to researching children's experiences is grounded in 'research *on*' rather than 'research *with*' or 'research *for*' children' (Darbyshire, 2000), thus not acknowledging the important contribution that children and young people have to make in giving their views and supporting the design and implementation of research. An event held in combination by The NHS Confederation, The Royal College of Psychiatrists and the Office for Public Management reported that 'children and young people need to be engaged early in the design of new health organisations and structures to ensure their views are included right from the start and regularly in the future.' (NHS Confederation, 2011).

There is now a drive to implement weight management for young people who are overweight or obese. Seeking the views and opinions of young people is clearly an important step in the development of such services generally. Therefore, understanding the views of the very children who such services are developed for would provide a valuable insight that may inform future service provision.

2.1.2. Research objective and aims

The overall objective of the current research was to explore the views of young people who are overweight about what they feel they need in place to support them to achieve a healthy weight. The research aimed to explore the following areas:

- 1) Young people's views on being overweight.
- 2) Young people's views on their own personal weight status.
- 3) Young people's views on what might need to be in place in order to support a young person to achieve a healthy weight.

2.2. METHOD

2.2.1. Design

This study employed a qualitative design undertaking face-to-face interviews with young people. A Grounded Theory (GT) approach was chosen due to there being little published research in the area. Grounded theory is valuable in this context as it is particularly useful in understanding 'the behaviour of groups where there has been little exploration of the contextual factors that affect individuals lives' (Crooks, 2001). Therefore this study aims to understand the views of young people

regarding being overweight in the context of a weight management programme (WMP). GT aims to develop a deeper understanding of individuals' experiences and to develop an explanatory theory by examining concepts grounded within the data.

2.2.2. Participants and recruitment

Participants were recruited from a local WMP. In order to be eligible to attend the WMP, all participants had their weight and height measured by programme staff. All participants were in the overweight category. The WMP was a 12 week course that consisted of a half an hour nutrition session with an hours exercise session. With the agreement of the WMP manager, the researcher was introduced to the groups in session 3, and so participants were recruited between sessions 3 to 12.

Eleven young people volunteered to participate in the study. Ten were attending a weight management programme at the time of recruitment, and one participant had attended a weight management programme (WMP) recently. The 10 current participants were at various stages of the group programme. The participants were aged between 11-13 years old, comprising 7 males and 4 females. The ethnic origin of participants included White British (n=5), Indian (n=1), Pakistani (n=3), Black African-Caribbean (n=2). The sample comprised two sets of siblings.

Both young person and parent/guardian were given written information sheets that detailed the aims of the study and what was to be expected. Two versions of the information sheet were developed and distributed, aimed to be suitable for both audiences, written using clear and accessible language, using short words and

sentences and free from technical terms (see Appendix C for both versions of the participant information sheets).

See Figure 1 for the full recruitment procedure.

2.2.3. Ethical considerations

This study was reviewed and given ethical approval by Coventry University Ethics Board and NHS National Research Ethics Service, West Midlands (see Appendix D).

Consent and assent were gained from parents and young people to take part in this study (see Appendix E for forms). The young person was assured confidentiality, and that they could withdraw from the interview at any time. They were offered the option of their parent/guardian to remain present during the interview, only one participant opted to do this however. Participants were made aware that they did not have to answer any questions. Ways in which participants could articulate this were discussed at the beginning of the interview. The researcher stressed that there were no right or wrong answers, and it was their views and opinions that were of interest in the discussion. All participants were given a £5 voucher as a thank you for participating in the study.

Names used in this paper are pseudonyms, and the data has been decontextualized in order to ensure that participants cannot be identified.

2.2.4. Measures

A semi-structured interview schedule was developed based on previous research that identified gaps in the literature, or where information on the chosen topic was more limited (see Appendix F). The interview items covered participants views on

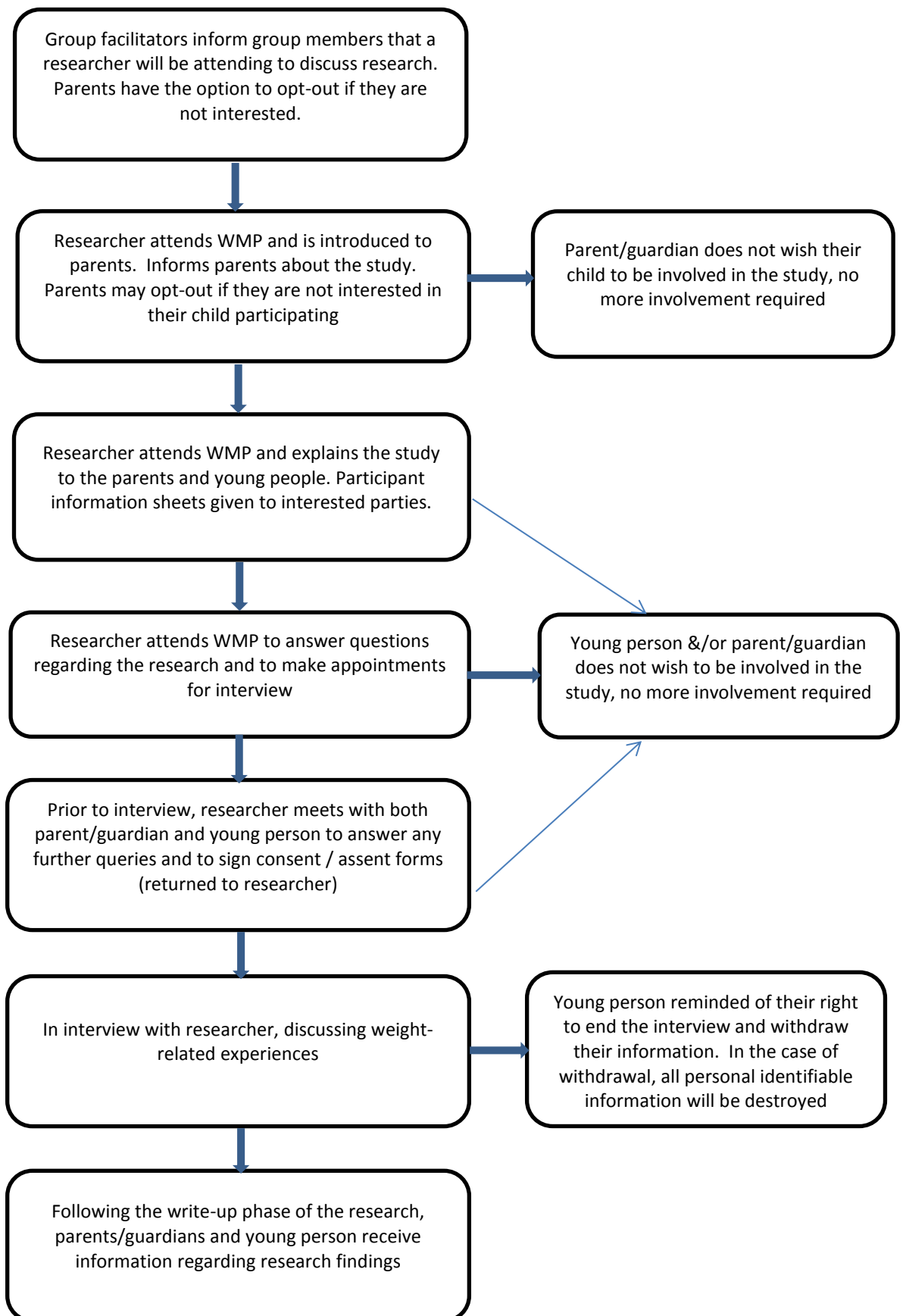


Figure 1. Recruitment procedure

their own weight status, others views on weight, exercise and dieting and views on possible support that may facilitate achieving a healthy weight. The schedule was used flexibly in order to allow the participants to give information that they deemed relevant. In order to build rapport with the participant, the researcher and participant also compiled a family tree. The aim was to settle and engage the participant into the interview process, similar to an 'ice-breaker' activity.

The interview schedule was piloted on two young people, aged 11 and 12 years old, who were not overweight. This was to gain feedback on the process of incorporating an activity (family tree exercise), and gain clarity on the questions. Amendments were made after the pilot.

2.2.5. Analysis of the data

The interviews were transcribed and analysed using the Grounded Theory procedures informed by Charmaz (2006) and Strauss and Corbin (1998). The initial stage involved examining each line of the transcripts and defining the actions and events that were occurring within it. This process is named *line-by-line* coding (Charmaz, 2006). Once this was complete, the line-by-line codes were condensed and combined to form *focused codes* (see Appendix G for an example). A large number of focused codes were produced, and so a process of *axial coding* was undertaken (Strauss and Corbin, 1998). This process aimed to sort the data further, making connections between the codes to give coherence to the data. This led to the development of *conceptual categories*. These encompassed common themes and patterns in the axial codes.

In line with grounded theory principles, data collection and analysis occurred concurrently. The data was compared with subsequent incoming data to find similarities and differences within and across interviews. This process, known as the *constant comparative method* (Glaser and Strauss, 1967; see Appendix H for an example) serves to inform the researcher of what data to collect next, and when data saturation was reached (i.e. when no new themes are emerging in the data). Saturation of the data had been reached by participant 11, and therefore no further participants were recruited.

2.2.6. Issues of reliability and validity

Qualitative analysis is inherently subjective and therefore a number of considerations were made. The researcher takes a constructivist grounded theory approach, which accounts for the interaction between the research and participants, with the researchers' perspective being part of the process. The researcher does have some previous knowledge of the literature and previous experiences of weight management which could potentially have meant that the researcher guided the interviews or data analysis to represent their own ideas. It is acknowledged that 'owning one's perspective' encourages transparency regarding the researchers influence on the data (Elliot, Fischer and Rennie, 1999). Steps were undertaken to account for this, including a process of 'bracketing' which was completed in order for the researcher to identify what she already knew about the experience being studied, and to approach the data being aware of any preconceptions (Ahern, 1999). A reflective journal and memos were also used to identify times when neutrality might have been compromised.

According to Barbour (2001), inter-rater reliability in qualitative methods is more concerned with the content of the disagreements in coding, rather than the degree of concordance. Having an independent researcher to examine the transcripts can facilitate a discussion that will help to refine coding. For this study, an independent researcher analysed a transcript and both the level of agreement and disagreement was discussed. There were two additional focused codes from the second rater, and these were explored more fully. The other codes were discussed; the main issue was around differences in terminology rather than content.

2.3. RESULTS

Using the Grounded Theory approach, four conceptual categories were established from the analysis of participant's interviews (see Figure 2). These categories represent the young peoples' experiences of being overweight and their weight management journey. The diagram demonstrates how young peoples' sense of self and how they make sense of being overweight overlap, but are central to their identity. This sits within the wider sphere of managing overweight and the factors that young people face in living with being overweight. Finally these categories sit within a wider systemic context; family identity, the impact of bullying, as well as understanding media influences on the portrayal of obesity. This diagram aims to capture the dynamic process of how all factors influence one another. In describing these conceptual categories below, there will be evidence of how the categories interact, as well as stand-alone as conceptual categories (see Appendix I for summary table of coding: focused coding to conceptual categories).

2.3.1. Conceptual Category 1. Sense of self

This conceptual category represents how a person views themselves in light of being identified as overweight and attending a weight management programme (WMP). Within this category are two axial codes: identity and body image.

2.3.1.1. Identity

A pertinent part of a person's identity was the awareness of their shape and size, and what this meant to them. For a number of participants, they identified that there was a process of acknowledging their size and wanting to lose weight, such as Joey who commented that *'I wanted to go to on one (WMP) because I know I'm fat...'*(p.11, 216-217).

There were links between how individuals perceived themselves (e.g. overweight / active) and their experiences of being in a WMP. Where participants had wanted to attend the WMP, and wanted to make steps to lose weight, they also seemed to benefit from being in a group experience. There was a sense of belonging, where people were similar to themselves and the experience was supportive, for example Libby commented:

'Cos everyone's in the same situation it's not like, embarrassing or anything it's like the same, so you feel comfortable' (p.6, L.157-158).

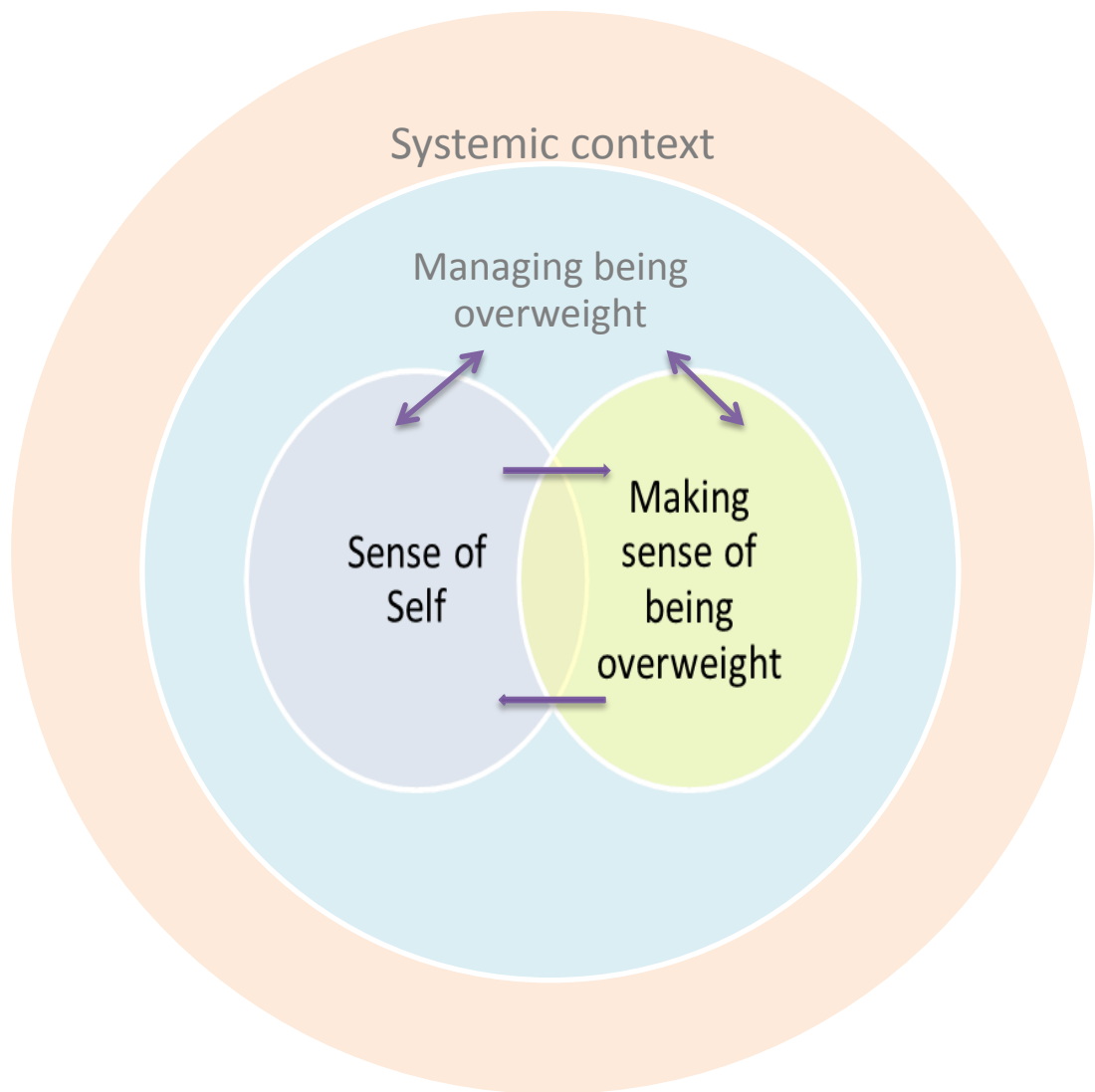


Figure 2. Model representing the outcome of the Grounded Theory analysis of understanding weight-related views and experiences of young people who are overweight.

On the other hand, where a person's sense of themselves did not appear to fit with the identity of the group, the experience of being in a WMP was more complex. Two participants had wanted to lose weight, yet did not enjoy the group experience. For example, both Rishi and Amir compared themselves to other group members and felt different to them, as demonstrated by Rishi:

'I see them but I wouldn't...I know they're like bigger than me...and I wouldn't...I'm not trying to like say I'm the skinniest there but I think I'm the most active there, like I run around more, like do all that stuff' (p.14, L.256).

An important part of identity development for these participants was the feedback and views of others. To some participants, the suggestion of attending a WMP had no impact upon them, whereas others experienced feedback as incongruent with their view of their own weight, and this raised a number of emotions. For example, Jake's GP recommended the WMP programme to him and he initially appeared surprised by this:

'I only got the real big concern when the doctor said 'you're a little bit overweight so we'll send you to the weight management programm'e and I thought 'how can I be that overweight?'. So that's when the concern set in' (p.12, L.289-291).

Some individuals described the process of comments being made about their weight from family members, and this took more adjusting to, depending on how aware they were of being overweight. For example, Abdul described not being

concerned about his weight at all until it was mentioned, which led him to *'feel like I was fat'* and he felt sad about it.

A key aspect to most participants' identity was being active. For nine participants, they engaged in regular exercise that was varied and seemingly high intensity. They all understood the balance of both eating healthily and engaging in regular activity. For both Chloe and Rishi, they acknowledged that exercise wasn't a problem for them as Chloe stated:

'I am very active but it's not that that affects me, it's all the fats that I have cos I like a lot of crisps and everything!' (p.10, L.194-196).

2.3.1.2. Body Image

Thoughts and feelings about body image were raised in some form by all participants. For nine participants, there was the desire to lose weight in general.

Some participants had a clear idea of what they wanted their bodies to look like. For Kamran, Joey and Amir, a particular body shape they were striving for was a muscular one, as stated by Amir:

'I wanna look like, tall. I wanna have a pack, like a 6 pack, and I wanna look really skinny' (p36, 741-742).

A desire for slimness was also indicated in Amir's quote above, and in more detail by Libby:

'I don't want a big tummy for a start...and I like...I wanna like grow, so I don't...cos when you grow it kind of like stretches out a bit and I want my thighs to be smaller and arms to be smaller and stuff like that...I just wanna look, like, thinner I guess' (p.14, L.288).

However, Rishi stated that he wanted to look *'like my friends, like skinny. Not skinny, but slim. Normal' (p.23, L. 456).*

A number of participants indicated self-consciousness about their bodies, whether that be embarrassment about having to be weighed and to discuss this with other people, or having to exercise in front of others. This closely links to their self-perception (Identity), the support they feel they have to make changes (Role of Support in Making Changes) and their own personalities (Personal Qualities).

For those participants who were striving for particular body types, there was the sense that their 'ideals' had been influenced by those portrayed in the media (see later section 'Media Influence').

2.3.2. Conceptual Category 2. Making sense of being overweight

As participants spoke about their journey with weight management, a conceptual theme emerged around how they make sense of their own weight and being overweight in general. From this, emerged themes about the physical impact of being overweight, the role of managing emotions by eating, and thinking around whose responsibility a young person's weight was.

2.3.2.1. The physical impact of being overweight

Participants described how being overweight impacted themselves, how it may impact others and what the consequences of that were. Physical health was mentioned by a number of participants with the impact of weight on being able to take part in sports and exercise being a concern for many. This was either a consequence they had noticed personally, or they had noticed in others. For example, Kamran noticed how his weight affected his pre-existing asthma and the impact of losing weight and stated:

'Asthma's gone down now cos of the exercise and everything...but then I got out of breath easily, increased asthma attacks, yeh loads of asthma attacks, yeh and I would have had to go off school cos I had asthma attacks, yeh loads of things got affected' (p.16, L.319-322).

There were also comments about the barriers to exercising and the physical consequences as Chloe described:

'I think it makes you tired in sports, which means you can't join in as much as you probably want to' (p.27, L.577).

Some participants mentioned concern about developing other physical health problems. Libby talked about the link between weight and physical health conditions in her family:

'Things like getting diabetes, cos my dad has diabetes...cos you know I could easily get that, like heart disease and stuff like that' (p.16, L.312).

2.3.2.2. Emotional eating

In considering how people might come to be overweight, participants demonstrated an awareness of the idea of using food as a means to cope with emotions. All participants remarked on the concept of emotional eating, and Rishi suggested that to some people *'food is like their friend'* (p.17, L.335) and maybe used in times of stress. Furthermore, Kamran normalised the concept by stating that *'I eat when I'm upset...so that's why...loads of people eat when they're upset.'* (p.25, L.502).

When discussing the idea of using food to manage emotions, this linked with a number of other axial codes. For example, emotional eating in response teasing was discussed with Joey:

'If someone's putting you down it'll make you just wanna eat more because you'll start thinking...you'll just start getting upset...or...people putting you down could just make you think 'oh, can I be bothered to do this 'cos what's gonna happen, I'm not gonna be able to lose the fat' (p.21, L.430-433).

Some participants didn't use food as a means to manage overwhelming feelings, but knew others who did, or were aware of this through television programmes

(discussed in Media section). For example Jake commented on a person at school who had been upset:

'well I've heard of it and I've definitely seen it,I can't remember but it's somebody at my school that was upset about their results or something and proceeded to...they'd bought out what they called an 'emergency chocolate bar' ...chocolate stained with tears, lovely' (p18, L482).

Two participants suggested that whilst they didn't use food to manage sadness, they lost their appetite when angry, for example Marc commented:

'Like, I don't see...why would you eat if you're sad? I'd rather not eat. Like sometimes if my mom's made something and I get angry I just go to my room and don't eat nothing as I don't want it' (p24, L473).

2.3.2.3. Responsibility for diet: 'whose responsibility is weight anyway?'

When thinking about the 'whys and hows' of being overweight, whether of self or others, some participants described how they now make efforts to manage their weight since attending the WMP, thus taking responsibility for it themselves. Joey commented that *'well I've always cooked, since I was like 7. But I can do more different meals now that are harder' (p.25, L.514).* As well as taking control over diet by cooking, others made decisions to limit eating the same as the rest of the family. For example, Libby reported that:

'Cos I know that in the week they just do like fish, chips and beans and I'm just like I'm not gonna eat that cos I know it's gonna affect my weight so I just have something healthier like pasta or the wedges' (p.24, L.501).

However, others described a lack of control over their own diet and how this impacted upon self-management. For example, a number of participants described how their food intake was determined by their parents. Abdul talked about mealtimes at home and commented that *'they're [parents] making fattening food'* (p.13, L.317), whilst Amir was trying to not eat sweets and commented that:

'I'm trying my best not to eat any skittles. My mom bought a whole packet and it's got 89.9 grams of sugar and I've just ate them all in one go' (p.18, L.353).

Chloe had initially tried to work with the food provided in sticking to her own diet:

'My mom used to cook the same meals that she used to cook, I just had to choose what I wanted, like, on the sides or anything' (p.22, L.468-469).

The more general idea of being overweight and reasons for that were described by participants. When the discussion was more externalised to talk about 'other people being overweight', different explanations tended to arise. Some reasons for being overweight appeared to be more around either statements of fact, or blaming the overweight individual. For example, a number of participants suggested that people simply may eat too much. Other thoughts focused on

individual's characteristics, such as Jenna who suggested that *'they can't be bothered'* (p.20, L.396) and Marc who commented that *'...it's just...their fault 'cos they're like that...because they eat too much'* (p.13, L.248-252).

Others talked about the unfairness in judging people for their size because reasons for it may be unknown. 'Fault' became a factor in not judging, as suggested by Nicole:

'If it was their parents like feeding them junk food and stuff, and if it's been that way since they were young and they've grown up with that and stuff. They're not gonna know of any different way so it's not really their fault...'(p.17, 482-484).

Another indicator of overweight not being a person's fault was regarding medical conditions. Chloe, Libby and Jake all considered medical condition or metabolism as cause for being overweight. Jake commented:

'Cos overweight people, I believe, have a slow metabolism and people with a faster metabolism have, work out a lot...' (p.14, L.361-362).

In drawing together the ideas around responsibility, there appeared to be a tension between when a young person moved from dependence to independence, and the impact this had on their choices regarding weight management. Chloe encompassed this idea in the following comment:

'... sometimes family don't really help...cos sometimes the mom buys all the sweets and everything for them, then they eat them and things... the parents give the child the pocket money but they don't go

out and say 'you can't buy this, you can buy this you can buy that', it's the kids choice what they choose to spend the money on' (p.20, L.422).

2.3.3. Conceptual Category 3. Managing being overweight

This conceptual theme is regarding how young people manage being overweight. This includes the importance of education and knowledge and what participants do with the information, the role of support in making changes, the dieting journey and finally the personal characteristics that they bring to their approach.

2.3.3.1. The importance of education and knowledge

For ten participants, it had been useful to gain nutritional information from the WMP. Specific information enabled participants to make dietary changes at home, for example Jenna remarked:

'I found out that 5 a day you can eat one of each fruit, not all the same' (p. 13, L. 256).

Gaining dietary knowledge also had an impact on the family, and thus made a difference to how participants experienced making changes. Kamran commented that *'my mom buying healthier food' (p.18, L.358)* had been helpful. Chloe also spoke about the impact on the family:

'She [mom] just trying to make her life healthier at the same time and cos she buys all the food, it will help cos she's getting all the information so it will make the family eat what she puts on the plate' (p.15, L. 295).

Conversely, Marc's experiences of education and knowledge were different. The essence of his position was how the information received wasn't relevant to the way that he eats, *'they keep giving us sheets and stuff and I don't even eat any of it on there...'* (p.22, L.452).

Although gaining knowledge was key to a person's ability to make informed decisions about what they were doing, there was interplay with other themes, such as the *role of support*, as well as discussion in *family identity*.

2.3.3.2. The role of support in making changes

Participants discussed how having support has helped them to make changes and the role of family support was key. Jake spoke about the practical support his mom provided:

'I've had a lot of help from her about my diet, I talk about it every time we're there. I sort of go 'oh, that smoothie that they recommended, I could try that' and she'll say we've got most of the ingredients of that' (p. 22, L.552).

Other parental support involved taking control of the participant's diet, for example Rishi described that his parents were *'trying to give me less food for dinner and that and then like, trying to hiding the crisps and all that!'* (p.13, L.253).

As well as thinking about making dietary changes, exercise was also considered by all participants, as discussed earlier. It seemed that for those most active, where exercise was a regular part of their life, they often did some activity with a parent.

For example, Libby and her dad were keen footballers and Chloe and her dad did Tae Kwon Do together.

Participants also discussed the nature of doing exercise with peers, and how encouraging this could be. For example, Joey, who had expressed how self-conscious he was about exercising at school, had a best friend who was sporty and supported him:

'...she'll [best friend] try and encourage me to go on jogs with her and stuff and like...say I, say I say 'can I come to yours for a bit' she'll be like 'no but you can go for a jog with me' and I'll be like 'oh ok...'
(p.13, L.267).

In discussing more widely about what people in general may need to help them to manage their weight, the essence was that it was more difficult to try to manage their weight alone. Kamran summed it up by saying *'they're gonna need supporters'* (p.28, L. 563).

2.3.3.3. The dieting journey

Dieting talk was prominent for all participants, perhaps given the emphasis of weight loss as part of the WMP. Eight participants described dieting attempts they had made before they attended the WMP. Attempts ranged from increasing exercise to food restriction. Dieting behaviour was reported at as young as 9 years old, but they had all attempted some sort of weight loss method prior to the age of 11.

Most common was attempting to restrict food in some way, usually by cutting out or down on particular foods, and in more extreme cases, cutting out food intake altogether. Amir attempted to restrict his food intake by fasting and described how difficult this was:

'I tried to eat nothing for the whole day and then I got back home and said 'I'm so starving' and she [mom] said 'have something', and I said to her 'I'm fasting' and she said 'you're too young for that', and then she bought wraps and stuff like that, she made 5 for everybody but I just ate them all!' (p.40, L.811).

Joey was the only participant to have tried other dieting methods such as Weight Watchers, which he attended with his mom, as well as meal replacements and slimming drinks. Joey described the difficulty in adapting to new diets:

'When you have the milkshake you still have to have one meal and then another snack, 2 snacks.. so you've gotta have a certain amount of the milkshakes, and a certain amount of snacks, a certain amount of meals' (p.14, L.287).

In talking about their current dieting, participants described what they were doing that constituted a diet. In the crudest sense, a diet meant eating more fruit and vegetables, and completely cutting out 'junk foods.' With this came comments around how difficult dieting was due to ruling out 'nice foods.' Some participants described how well they were doing because they had managed to stay on their diet, such as Amir who commented, *'I've stopped eating sweets, chocolate, crisps,*

my mom don't get any crisps at all, I haven't even had one ice-cream for like 3 months' (p.27, L. 555). Participants talked of either eating 'good foods' and thus being on a diet, or 'failing' by eating bad foods. Kamran indicated this pattern in his dieting:

'Because I've been weighed today I've put on weight, not that much, a little bit, but because I've been craving chocolate' (p.10, L.187).

A few participants described the cycles of unhealthy eating that people might get themselves into that are unhelpful. For example, when Joey had noticed his Nan's eating patterns and described:

'Like instead of having her regular meals, she'll probably just have breakfast biscuits in the morning, and then in the afternoon she'll have...lunch and tea at the same time, so she'll have twice as much for tea which doesn't help' (p.17, L347-350).

Nicole and Jake's outlook differed slightly, in that they had more positive experiences of dieting. Jake stressed the importance of a balanced diet, and Nicole had found that dieting hadn't been as challenging due to the tips they had been given at the WMP. She mentioned a specific strategy of making small 'swaps' in her diet that helped, *'... like doing little swaps because they do make a big difference and...it doesn't feel like you're on a diet, it just feels like you're being healthier'* (p.13. L. 367). Nicole's experience demonstrated how a diet might be less challenging if it caused less disruption in day-to-day life.

Overall, participants expressed that dieting was very difficult. There were lots of things to think about in terms of what one needed to do to lose weight and how to implement those changes. Abduls thoughts on dieting were *'well it was quite hard because you can't eat everything you want anymore' (p.8, L.191).*

2.3.3.4. Personal Characteristics

Throughout the discussions with participants about their experiences of weight management, and how they were doing with the WMP, their approaches and attitudes towards weight management were prominent. Many participants voiced motivation to want to manage their weight and were fully engaged with the process, despite the difficulties they had expressed as discussed above. Jake commented that *'I would like to lose some weight and I've actually got on a bit of a path now' (p.10, L.254).*

These participants were also motivated about exercise, and generally enjoyed the sports session at the WMP. Joey emphasised the importance of finding exercise that you like:

'If it's an exercise you don't like, you don't wanna do it so you don't put effort in. So like, I can go on the trampoline for 3-4 hours straight without worrying but, if it was like, having to do a jog or run around a field for an hour I just wouldn't bother, I'd just walk!' (p.18, L.368).

Amir had gone to the WMP looking forward to learning new skills in sports, *'I was wondering if I was gonna have a better coach person like teaching me to play properly'* (p.20, L.403).

Some participants also showed enthusiasm for cooking, and were keen to be able to cook, especially since learning about healthy foods. Joey and Kamran were already keen cooks, helping out at home. Jake, Libby and Chloe were keen to get more skills in this area.

Over the dieting journey, the emotional impact of managing weight was important for participants. Some participants were a driving force in wanting to attend a WMP, such as Libby, Joey, Chloe and Nicole, who were having positive experiences overall.

However, there were also suggestions that being overweight caused some level of anxiety amongst the participants too. For example, Rishi was very worried about his weight and found it difficult to talk about at times. He described feeling disappointed about being identified as overweight, and was upset at *'just seeing other people improving and I'm probably not'* (p.10, L181). Furthermore, Chloe had also been concerned about her weight and commented that:

'I'd say I was a bit bothered about me like, getting too fat but, since I've been going here it makes me less worried' (p.12, L.238).

Where weight wasn't a concern, there was seemingly little impact emotionally on having to attend a WMP and address weight. For Marc, who clearly stated that he didn't think his weight was a problem, he demonstrated a confidence about weight not being a difficulty for him, *'that's the thing, I wouldn't get big. I just know I wouldn't'* (p.32, L.643).

2.3.4. Conceptual Category 4. Systemic context

As well as there being individual factors that influenced the experience of being overweight, participants spoke of external influences that shaped their experiences. Such factors included family identity, role of teasing and media influence. As demonstrated in the diagram, all other conceptual categories interact with this under the wider systemic context, showing how wider systems can shape individual's experiences.

2.3.4.1. Family Identity

The role of the family was a strong theme throughout all participants' experiences regarding weight. Participants described a family approach to food and dieting, as well as individual family members' relationship with food.

A number of participants described that other family members were also dieting, for example Joey said:

'My sister's like a really fussy eater. But my mom, she eats whatever, like I do....But my dad's side of the family eat...they're quite bulky like, they're a bit...obese because they do eat quite a lot' (p.17, L.340-344).

Other participants described a whole family approach to weight management, and some suggested that the primary concern was around healthy eating as opposed to dieting. For Nicole, she wasn't really aware of people in her family going on diets, and described that they were different shapes and sizes:

'Me and mom would always talk about being more healthy, but not about losing weight' (p.12, L.346).

A family's approach to exercise and activity also played a part in a participant's interest in activity, as mentioned earlier in the section re *'Identity.'* If a family is generally active, again this seemed to influence a person's motivation for engaging in exercise.

2.3.4.2. Peers and teasing

Another aspect of the wider context was that of how others perceive and judge those who are overweight. Dominant within such discussions were issues around being teased and bullied, usually by peers, and how this may impact upon a person's ability to make changes. For example, Rishi demonstrated the interaction of others' teasing and the impact on emotional wellbeing:

'Probably people teasing and putting them down, so they comfortably eating things, like that food is a friend, they just eat the food so they get bigger and bigger' (p.25, L.492).

A number of participants described having had experiences of teasing and bullying about their weight, or knowing someone who had. For Joey, this had impacted upon his confidence greatly:

'They make fat jokes about ya, and things like when you do PE and you're running, and say you have moobs or something, they start on you and then they'll start saying you need to get a bra and stuff like that...and it's kind of like bullying basically' (p.12, L.245).

Participants who hadn't experienced bullying still worried about being bullied because of their size, as there seemed to be an acceptance that some level of teasing was inevitable, as Jake said:

'I was bullied at one point, which I think maybe, almost every person goes to a school may have experienced at one point. It's pretty much...you can't avoid it forever. You'll get bullied at one point' (p.22, L.591-593).

When thinking more generally about the possible impact of being overweight, and externalising the concept of overweight, other thoughts were generated regarding the difficulties people may face. For example, Jenna had thought that as well as people being unhappy about being overweight because they may not be able to participate in activities like other people, they may also worry about what others think of them:

'...that people won't like them and will probably think that people are talking about them or if they get bullied' (p.18, L. 370).

All participants worried about being bullied, knew someone who had been, or had experienced bullying themselves. Such worries and experiences about bullying influenced other aspects of life, including emotional eating, dieting experiences and potentially the motivation to make changes.

However, it was also apparent that one's own character also shaped the ability to deal with bullying. For three participants, they spoke of a more resilient response

to bullying. Nicole suggested the bullying might impact upon a person more positively:

'I don't think it would stop them trying to lose weight, I think it would encourage them more, like to prove their point' (p.16, L.450).

Chloe described how her best friend was teased due to her size and how it 'got her down', but how her resiliency got her through that time:

'...she gets judged a lot about it, that's what made her get into it. But then after that she was proving them wrong, that she's not, which I thinks good' (p.19, L.390).

And for Joey, who had experienced bullying, he also described the determination to build his confidence back up by means of focusing on his strengths and qualities, and moving his focus away from his size:

'I've tried to rebuild my confidence and I can because of things I've done like, people praise me and things so it gives you more confidence but then, they come back and knock you down, but then you get back up' (p.16, L. 317).

2.3.4.3. The influence of the media

The role of the media was drawn upon by a number of participants; it spans other subthemes across this model, but is also important in its own right. Some participants talked about how images in the media might influence a persons emotional well-being and potentially body image. For example, Nicole commented:

'Cos if you see in the media that someone is completely opposite to you and only people who are completely opposite to you in the media, then that's gonna have a downside, but that might cause them to comfort eat and become more obese' (p.11, L.294-297).

Understanding of how being overweight was thought of by others was talked about with a number of participants. How obesity was portrayed in the media was considered. Amir had Google searched 'why do people eat so much and become fat?' and described the following:

'...and it comes up with 'people are fat because they like to eat fat and they just wanna become fat' and then I put the same thing on images and there was this really big person who weighs one tonne, maybe two tonnes, and he was really really heavy, and he was absolutely fat' (p. 41, L.845).

Television programmes were also mentioned regarding extreme obesity. Both Nicole and Marc had watched a particular programme portraying obesity, and Marc commented:

'Like those people who can't get out of bed and have to have people to help wash them and stuff' (p.33, L.665).

When thinking about the emotional impact of being overweight, whether it be via family influence or as a result of bullying, the notion of 'comfort eating' had been learnt through popular TV dramas for teenagers, programmes such as mentioned above, and children's films. Chloe described the following:

'I watch a programme called Waterloo Road about, cos that sort of shows a lot about people's emotions and there was this one episode where this kid was so wound up and upset about his family, he just kept eating cakes and everything to make himself sick' (p.33, L.525).

When considering things that may contribute to a person's weight gain, there was some mention of the influence of advertising. Chloe described the difficulty around the advertising of sweets to make them appealing:

'I think it's just all the adverts and everything, it's like the Haribo tele tangtastics, they look really nice on the advert and it does make people buy them ... they look nice on the packets and stuff, especially your friends that eat them, they get you into them' (p. 20, L.409).

Chloe had also suggested that the media could be used to influence healthy eating by showing advertisements where people make healthy choices rather than advertising unhealthy foods.

2.4. DISCUSSION

2.4.1. Summary of the findings

The aims of this study were to gauge young people's views on their own weight status and being overweight in general. There was also an interest in ascertaining what might need to be in place to help people achieve a healthy weight. The results of this study produced a model of young people's experiences of being overweight. This model suggests that an individual's sense of self and how they make sense of their overweight are closely connected and influence one another.

This self-focus is embedded in the experiences of managing overweight, which involves the utilisation of resources such as education and knowledge, as well as support from others in order to make changes. These axial codes interact with the dieting journey. Encompassing all of these experiences, is the wider systemic context. This considers how 'others' impact on their views of self and how they manage, as well as the influence of the media in its portrayal of overweight and obesity. The model aims to portray the interaction of such concepts, rather than a linear process. A person's sense of self will impact upon how they manage their overweight and influence how they deal with the portrayal of obesity, for example.

The participants' views and experiences in this study inform our thinking around what might need to be in place in order for a young person to achieve a healthy weight. Receiving support from the wider context, such as taking a 'whole family' approach to healthy eating and participating in exercise was important. Furthermore, having a 'buddy' or 'supporters' in the process gave a sense of belonging and encouragement to make healthy dietary choices.

2.4.2. Relating to previous literature

Participants in this study had talked about the group experience and either finding a 'sense of belonging' or not. This notion of 'fitting in' is consistent with literature around identity. Miles, Cliffe and Burr (1998) suggest that early teenage years are important in terms of peer relationships, and that school and college years provide an environment for young people to experiment with ideas and personal meanings within an established reference group. Participants in this study were trying to gauge a sense of 'fitting in' in the WMP. In this study, 'being active' was part of a

person's identity construct also. Although this study only contained four girls, all of them were very active and stated their like for sports and exercise. This is in contrast to previous literature that demonstrates girls tendency to disengage with sports at secondary school (Williams, Bedward & Woodhouse., 2000), but is supportive of other findings that young women gain a sense of physicality through sports which is empowering (Garrett, 2004) and enhancing health and well-being (Brooks and Magnusson, 2007).

Body image was an important consideration to the majority of participants in this study. There is a wealth of literature to support the notion that both young males and females aspire to have certain body shapes. Some boys in this study spoke of the 'muscular' body shape as the ideal, which is consistent with previous research around a drive for muscularity, typically for males (McCreary and Sasse, 2000; Morrison, Hopkins and Rowan,. 2004). Cohane and Pope's (2001) review of boys and body image, found that many boys reported dissatisfaction with their bodies, associated with reduced self-esteem.

It is well documented that there is a greater body dissatisfaction in girls, as identified in Ricciardelli and McCabe's (2001) review of body image concerns and eating disturbance in children. Interestingly, only one female in this study commented on dissatisfaction with her body shape which was in line with the well documented 'drive for thinness' phenomena (see Grabe and Ward's (2008) meta analysis). In this study, two girls focused more on 'being healthy', and discussing health-related consequences of overweight, which is contrary to other studies

where health related consequences weren't considered, such as the qualitative study of Wills, Backett-Milburn, Gregory and Lawton (2005).

Finally, one participant did not express any views on body shape at all. This girl was the youngest participant, having just turned 11 years old. However, developing views on body dissatisfaction and image may be linked with developmental stages of pre-adolescence to adolescence, where adolescence may be regarded as particular time of vulnerability (Wardle and Cooke, 2005). This participant hadn't quite reached the adolescent stage and was perhaps less vulnerable to having poor body image.

Many participants raised the issue of being concerned about bullying or having experienced teasing and bullying themselves. Such experiences and concerns were well-placed, as obesity is a stigmatized condition, in which weight-related teasing is commonplace (Puhl and Latner, 2007). The emotional impact of being overweight was also linked with how overweight people are judged negatively by others, and the anxiety and concern that that brings. However, it was also notable that three participants described such perceptions as possible potential motivators for change. It was interesting that these participants made such comments, being overweight themselves, and is not supported in the literature. Indeed, the literature suggests that individuals cope with weight-related stigma by eating more and refusing to diet and thus contributing to further weight gain (Puhl and Brownell, 2006). It may be that for these participants, factors such as resilience and family support enabled them to take on a different perspective to managing stigma.

The discussion around responsibility raised interesting ideas within this study. Participants either viewed a person's diet as their own responsibility or at the hands of others, usually within the family system. For those who had a higher sense of autonomy, the concept of being responsible for managing one's own weight is supported by other research (e.g. Wills et al., 2005). The idea of whether a person's diet is their responsibility or not may reflect the developmental stage at which the young person is at e.g. no sense of control over diet may be linked to the developmental stage of pre-adolescence. The sense of adolescent autonomy is discussed in the literature and the notion of 'cognitive autonomy' was defined as "a sense of self-reliance, a belief one has control over his or her life, and subjective feelings of being able to make decisions without excessive social validation" (Sessa and Steinberg , 1991) may be relevant here. At present there is little research regarding health behaviours and autonomy in adolescents (Spear and Kulbok, 2004), although the sample in this study appear to reflect the crucial stage in early adolescent development involving the move from dependence to independence regarding their own health behaviour. The notion of adolescent autonomy is also relevant when considering the role of family identity. Spear and Kulbok (2004) suggest that rather than striving for complete independence, young people perhaps strive for interdependence, balancing independence whilst remaining connected to the family.

The family's identity and relationship with food was an important part of an individual's experience. Participants were aware of dieting practices, and some had directly observed family members struggling with their own weight management

journey. It would therefore seem natural that being in this context would influence a young person's own relationship with food and activity. There is research that advocates that because parents are key to providing a child's contextual environment, they should also be key players when considering interventions for a child's weight management (Golan and Krow, 2008).

Various forms of the media were drawn upon throughout discussions with participants in this study. One participant talked about food advertising and the influence this has on her and her friends' food choices, especially regarding sweets. Food advertising has received the most attention within the realm of media influencing obesity, studies demonstrating high associations between adiposity and the kinds of advertisements directed at children (UK Food Standards Agency, Hastings et al., 2003). Interestingly, this participant also suggested that the media could promote healthy eating in its advertising instead, which has also received some attention in the literature (Bond, Richards and Calvert, 2013). It is also interesting to note that other forms of social media, such as Facebook, was not mentioned by these participants. Possible reasons for this may be that it was either not important to them or perhaps that media exposure is so engrained in everyday life that it is more implicit in their experience.

2.4.3. Study strengths

This study aimed to seek the views and opinions of young people who were overweight, regarding weight-related experiences. This study focused on early adolescents as a means to contribute to a dearth of literature specifically focusing on those who are overweight. The inclusion criteria aimed to provide a basis for

homogeneity, as all participants had been or were currently involved in a weight management programme.

The weight management programmes were held in a diverse area, and this resulted in more children from Black and Ethnic Minority (BME) groups. This sample therefore reflected the demographic of the population of the local area, and therefore some level of generalisability to that population is possible. Participants were selected from a weight management programme, whereby all young people were aware of the purpose of the group and the requirements for being able to attend i.e. being overweight.

2.4.4. Limitations

Unlike quantitative data, it is not the intention of qualitative research to produce results that are generalisable to the wider population (Giles, 2002). However the model that has been produced here does reflect the participant's experiences, and partial generalisations could be made to other young people who are overweight and taking part in a weight management programme. Saturation was reached within the data, however a larger sample size may have offered more perspectives should a greater number of females been involved. However, it is worthy to note that there were potential participants who may have offered different perspectives should they have volunteered to take part. Whilst parents were happy for their child to take part, they explained that some had then refused due to feeling embarrassed or self-conscious. This was particularly pertinent to young females.

As with all qualitative studies, there is the potential for bias of the researcher. However, in GT the role of the researcher's interpretation is accepted and taken into consideration as part of the research process through a reflective journal and memos.

This sample contained two sets of siblings. In one set, where lack of concern regarding weight was expressed, it could be possible that there was a family script around this, or one sibling was highly influential over another. However, the other set of siblings appeared to differ in their experiences slightly, despite living in the same household and attending the same weight management programme.

2.4.5. Clinical implications

This model suggests a diverse range of experiences regarding weight management. The clinical implications of this suggest that motivation, self-esteem and emotional regulation may need to be incorporated into weight management programmes that currently have a nutrition and exercise focus. Ensuring that families are on board with supporting their child in the weight management journey would provide a good platform for children to make change. Finally, having discussions with young people about what health, dieting and exercise means to them would be a useful exercise in order to gauge how to present information regarding making changes to diet and activity. This sample was aged between 11-13 years old, and it was evident that developing one's autonomy had implications for weight management. Consideration for a young person's stage of development is therefore important, especially where interventions consider the child as the main agent of change. Furthermore, this could inform good practice in grouping young people into

intervention programmes as well as when thinking about responsibility for change, peer and family influence and developing resilience and coping strategies.

Further clinical implications include tailoring weight-management interventions to individuals, as some people do not find the group experience helpful or conducive to making changes, as was evident from some participants in this study. Future group programmes could also consider having groups for narrower age brackets, and pay further attention to the impact of peer and family influence on making changes, as well as supporting children to build upon personal characteristics such as resilience and coping strategies.

2.4.6. Future research

Future research could involve looking at motivations to change for young people identified as overweight. Gauging this at the onset of participation of a WMP could provide invaluable information on shaping intervention. Research could also look to understand the potential impact of working with siblings when addressing weight management. Furthermore, exploring the efficacy of interventions that adopt a 'whole family approach' to understanding relationships with diet and exercise, in comparison to working with individuals, may be beneficial. Lastly, this sample represented BME groups, and therefore, understanding the impact that living within two cultures may have in relation to diet and exercise in different ethnic minorities in this country, may also inform what influences young people's food and exercise choices.

2.5. CONCLUSION

This research aimed to explore young people's views and experiences of being overweight. Using a Grounded Theory approach, a model was developed that represented participants' views and experiences. The key categories reflect how their sense of self and how they made sense of being overweight overlapped, and how this process sits within the wider concept of the factors they face when managing being overweight. Lastly, such experiences sit within the wider systemic context. The clinical implications of this suggest the inclusion of addressing the emotional aspects of being overweight which can influence a person's weight management journey, as well as tailoring interventions to those who may not benefit from being part of the group process. Future research would be beneficial in the area of understanding interventions for the family as a whole.

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Chapter Three

Reflective Paper

**‘Making sense of being overweight’: Reflections on
talking with young people about weight management**

Word count: 2527 (excluding references)

3.1. INTRODUCTION

My thesis includes a literature review of the attitudes towards weight loss and dieting in ethnic minority groups, and a grounded theory study of young people's views and experiences of being overweight. The aim of the reflective paper is to explore some of the themes that arose from the grounded theory analysis and reflections on my relationship with the themes. I also aim to reflect on working with young people, and what I have learnt from the research process.

3.1.1. Grounded Theory Model of weight-related experiences; what 'fits' for me

During the process of speaking with the young people in my research and analysing their transcripts, there were a number of thoughts and feelings evoked in me about them and their experiences of weight management.

Participants talked about the weight management programme (WMP) and naturally they described their dieting journey and the variety of experiences that they had had along the way. I was struck by how adult-like they sounded when describing having to 'get back on track' after a change in routine, or having cravings for particular foods, considering their young age. Dieting had an emotional impact, and many of them had exclaimed that dieting was hard.

Listening to young people talking about their dieting journey was difficult at times, but also made me think about what I was like at that age. I, too, had started to try and make adjustments to my diet in order to lose weight, and similarly to them, it was hard. There had been an emotional impact on me too, as I felt different to my friends and self-consciousness also prevented me from participating in sports and

general exercise. However, this is where my experiences differed to most of the participants. Being active was a strong part of their identity, and they embraced it. In fact, a couple of participants acknowledged that exercise wasn't a problem for them as they did enough, they just needed to address their eating habits.

Participants all had an awareness of emotional eating, whether it had been from portrayals on television programmes, peers, or using food to manage their emotions themselves. It struck me, when talking to participants, that despite their young age many of them had an awareness of the notion of using food as a means to cope, or to make themselves feel better. This made me reflect on my own relationship with food, and whether or not I use food as a means to manage my emotions. For example, when coming to write this thesis, I had made a decision to 'not be concerned about what I was eating', perhaps because constantly keeping an eye on your food consumption is actually quite effortful, and I thought I wouldn't really have the resources to spare. I am also aware that I strongly link eating with social occasions, so going out for dinner with friends is a means of celebrating an occasion or seen as a 'treat'. However, there are also times where I have used food as comfort, and have noticed my consumption of 'unhealthy foods' (which were described by the participants) increased over the write up period and my exercise routine diminished, despite knowing the benefits to both a healthy diet and exercise on well-being.

All participants made reference to the nutritional information that they had learnt from the WMP. Most of them thought it was relevant and had helped them to make changes. Just learning about 'swaps' and the notion of '5 a day' had been

really useful. It reminded me of when I had learnt about healthy eating, and it was ironically when I was working in an Eating Disorders Service prior to training. It was there that I learnt about the importance of eating regularly, and understanding how the metabolism worked. Furthermore, I learnt to understand the psychological impact of 'being on a diet' and the nature of restricting certain foods, and categorising food into 'good' and 'bad' (Fairburn, 1995).

There are a plethora of 'fad diets' around now, and I was surprised by how much the participants in the research knew about them. But with advertising on television and looking in magazines as well as material online, children are subjected to this more. It almost feels like 'being on a diet' is more commonplace than not being. And with so many types of diets being available, it might make it hard to remember the general principles of eating well and I wonder whether the 'quick fix' of a diet gets in the way of trying to be healthy. I wondered if anyone really knows what 'normal eating' is anymore. One definition summarises that 'normal eating is flexible as it varies in response to your hunger, your schedule, your proximity to food and your feelings' (Satter, 2009). Any group where diet is the focus, is going to seem like it advocates a healthy diet with a range of foods, and I have certainly experienced that in my previous dieting attempts with well-known commercial diets. However, regardless of the intention, my experiences were that it was (and still is) stressful to 'go on a diet', and it's easy to fall into a trap of feeling guilty about eating unhealthy food and 'treating yourself' as a reward.

Making changes and having support to do so, was also an important factor for the participants in this research. Family members played a big role in the realm of

support, although peers were mentioned by some too. Importantly, the knowledge they were gaining from the weight management programme was also a catalyst for change, and so there were a number of variables at play. Hearing the participants' experiences of making change and how they much they were utilising those around them, made me consider my own journey in making changes to my diet and exercise routines.

Like in the model, due to the knowledge I gained about eating regularly I began to make changes. A previous supervisor had noticed that I didn't eat breakfast and because she had raised the issue of 'practicing what you preach'; I decided to make that change to my routine. It was difficult! We are creatures of habit and my morning routine had not been changed for about ten years. As an adult, completely in charge of my own diet, the only barrier to me making that particular change was me. However, thinking about how children are in a family system, I wondered whether there were further barriers to making changes. For example, if breakfast wasn't part of an established family routine, then how would the young person make that change? Although a lot of the participants in this study were motivated to make changes, it did cross my mind that perhaps it was the environment (e.g. the family home) that needed to change in order to promote healthier choices for the young person living within it (as proposed by Golan and Weizman, 2001).

Further to changes in eating, I also started to exercise. Again, incorporating exercise into my weekly routine was difficult, but having friends to go with was a great support. And although I had dabbled with exercise when I was younger,

usually outside of school, it was sporadic. This time, because I had people to go with, I started to exercise regularly. It took me a while to find out what kind of exercise I liked, which was similar to the sentiments of one of the participants who also raised that point, and in a way I found exercise classes more motivational than working out on my own.

3.1.2. Gaining a different perspective

There were a number of topics raised that were interesting because they were so different to my own experiences. For example, one participant spoke mainly of the benefits of being overweight and how weight wasn't a concern for him. I hadn't made any consideration at all that individuals may not be concerned by their shape, especially as they had been advised that they were overweight and a weight management programme had been recommended. This made me reflect on the literature review around the idea of how some ethnicities might be more tolerant to a larger size, as outlined in Chapter 1. I wondered what the impact might be on a young person who has a positive attitude towards their own shape and size, and yet receives feedback to the contrary. It was uncomfortable to think that a person's confidence might be undermined, and them being asked to make changes to something that they didn't have the motivation to change. I even considered whether the questions asked in my research would exacerbate this label of 'overweight' that didn't fit with their identity.

Bullying, whether it was concerns about the potential, or actual experiences of it, were expressed across all participants' experiences. I reflected on being a teenager and what school was like, and how peer relationships and 'fitting in' were so

important at that time. I have been fortunate to have not been bullied, and as an adult, it's not something that I think about at all now. Although I was overweight as a teenager and right through until my mid-twenties, I also didn't experience negative judgments or discrimination for my size (as far as I'm aware). But, as in the literature (e.g. Puhl & Heuer, 2009), these participants were very aware of the stigma attached to being overweight, and it was therefore understandable that this caused concern for them.

It was interesting how a number of the participants had watched programmes about dieting, and they are common place nowadays. It made me wonder about the portrayal of obesity in the media and how that influences people's perceptions of obesity. For example, one particular programme films people in their home to work out why the participants are overweight, as the individuals struggle to understand their weight gain. Although the sentiment is around raising awareness of 'hidden calories' and mindless eating, I personally find the approach quite shaming. This programme appears to locate the person's weight problem entirely within the individual, and fuels the already well-established negative attitudes towards people who are overweight. I wondered what impact this was having on young people, both in terms of shaping their views on people who are overweight, and their own emotional well-being.

3.1.3. Reflections on working with children

Over the course of the research process, there were many learning opportunities for me. The most pertinent was perhaps working with young people, and engaging them in this process. I hadn't had much clinical experience of working with young

people before, and wasn't sure of how they would manage in a one-to-one situation with someone they didn't know and how I should 'be' with them. Like anyone in that kind of situation, it was variable. Some participants were keen to share their experiences and were comfortable about being in that situation. Others were tentative and shy, and were perhaps more apprehensive about the whole process. This left me in a more tenuous position as I needed to gauge the difference between nerves and a person no longer wanting to participate.

One thing I was concerned about was the issue of 'wasting time' in the interview. I did a family tree as a means of trying to do an activity that wasn't too demanding of them and get them talking about things they knew about before moving into the questions I had about weight management. Whilst in the interviews I was aware that for some, this process seemed to take a really long time and I was concerned that I wasn't being very efficient. However, another part of me thought that perhaps they just needed that time, or they were nervous, and so it was a constant dilemma for me about how to manage the beginning of the interview. In thinking about research with children, Morrow and Richards (1996) state that time is of importance and the research interaction needs to allow for a relationship to develop between the researcher and the participant. Developing a rapport with the participants was important, and I think that those who had seen me at the weight management group a number of times, understandably felt more comfortable with me by the time it came to sitting and talking to me.

On reflection, I wonder whether I had initially thought of teenagers as 'mini adults', whereby my approach to the research was the same as it would have been for adult

participants. I also reflected that because the young people in my family were chatty and outgoing, on commencing the interviews, I had maybe assumed that people volunteering would be the same, simply because they had opted to take part in talking to a stranger. James, Jenks and Prout (1998) suggest there are generally two types of approaches researchers may take when considering working with children. One approach is to just regard children as essentially indistinguishable from adults; the other is to see children as very different from adults and thus taking a completely different approach to research with them. However, James et al. also suggested a middle ground, that children could be perceived as similar but with different competencies. I think that, although I had endeavoured to ensure that my participants wanted to take part, and on the whole they did, there were perhaps some children that were not as comfortable as others.

Another factor to consider during the research process was the role of being a researcher, but also being a clinician. At times during the interviews, I was concerned for those that expressed the emotional impact of being overweight had had on their lives. It was clear to see that some had low self-esteem and were struggling with the demands of changing their diet or feeling different to others and feeling as though they were not achieving their weight loss goals. It was also challenging to listen to anecdotes of dieting behaviour cognitions that had a flavour of distortions within 'eating disordered thinking' (Fairburn, 2008) and having to make clinical judgements on whether there was a concern, whilst wearing a researcher's hat. With one participant, I did decide to talk to the parent about what had been raised within our interview, with that participant's consent. And

whilst I could do no more than inform the parent and refer back to the guidelines for accessing further support within the participant information sheet, it did make me appreciate both facets of the role of being a Clinical Psychologist.

3.2. CONCLUSIONS

The nature of this research has been both thought-provoking and personally challenging. The issue around being overweight is particularly topical at present, and having been immersed in this topic area during the research process, it has naturally made me consider my own relationship towards diet and exercise. I have learnt that obesity is complex and not a simple matter of making adjustments to one's diet as there are many factors that influence a person's motivation and ability to make changes. This process has heightened my interest in how Clinical Psychology can play a role in weight management and an area of work that I wish to pursue in the future.

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APPENDIX A

Author Guidelines



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ABOUT THE JOURNAL

Aims and Scope

The *International Journal of Obesity* is a multidisciplinary forum for basic, clinical and applied studies of the biochemical, physiological, genetic, molecular, metabolic, nutritional, psychological and epidemiological aspects of obesity and related disorders.

Topics Covered

Molecular, cellular, animal, human experimental and clinical studies, which address issues related to the development and treatment of obesity, and the functional impairments associated with the obese state. The problems of obesity are multifactorial, and the *International Journal of Obesity* will expect to publish articles with biological, psychological, clinical, sociological and environmental approaches to these problems.

Due to the high volume of submissions that the Journal receives, the following manuscripts will be deemed low priority:

- Simple prevalence studies involving a single country at a single time-point.
- Studies that merely confirm established facts from previous publications and that contain little new information. For example, it is hard to justify publication space for studies that report obesity is associated with known health risks. Therefore, studies that replicate the findings of previously published papers will tend to have a lower priority. If similar data are already published, it will be critical for authors to explain the novelty of their manuscript in the covering letter to the editor.
- Those that involve co-morbidities of obesity (e.g. diabetes, cardiovascular disease), without having obesity-specific components to them. Recent examples include manuscripts that look at associations between inflammatory markers and diabetes or cardiovascular disease. This information is clearly of medical relevance, but it is not necessarily a high priority for a journal devoted to obesity research.
- Those that report the absence of links between obesity and a specific genotype or polymorphism; it is possible that such work could be considered in the form of a Short Communication, but a full manuscript is not justified.
- Those that describe anthropometric indices of obesity that might correlate with plasma markers of co-morbidities, but do not include any data relating to outcome of the co-morbidities.
- Retrospective studies, secondary analyses of data that arise from studies that were not primarily concerned with obesity or body weight, or clinical "audits" (for example of surgical interventions) that were not designed as appropriately

controlled clinical research interventions, unless there is particularly novel information presented that is of importance to the medical literature.

- Those that claim to be pediatric articles but which do not deal specifically with children and adolescents up to the age of 18 years.
- Case reports that do not describe a critical finding or major addition to the literature.

If authors wish to submit articles to the *International Journal of Obesity* in the above areas, they would need to state clearly in the covering letter and introduction to the manuscript what is novel and informative about the study and why is it a valuable addition to the scientific literature.

Journal Details

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ARTICLE TYPE SPECIFICATIONS

ARTICLE DESCRIPTION	ABSTRACT AND KEYWORDS	WORD LIMIT	TABLES/ FIGURES	REFERENCES
Original Articles Please see 'Preparation of Original Articles' below for further details	Structured abstract: • Background/ Objectives • Subjects/ Methods • Results • Conclusions 3–6 keywords	Abstract: 300 words Article: 4,000 words max excluding abstract, references, figures and tables.	Max of 6	Max of 60.
Short Communications These are studies that fall short of the criteria for full Original Articles (e.g. preliminary experiments limited by sample size or duration, or novel hypotheses). Apart from including an abstract, there is no obligation to divide the text into sections.	Unstructured abstract 3–6 keywords	Abstract: 200 words Article: 1,500 words max excluding abstract, references, figures and tables.	Max of 2	Max of 20
Reviews (by Editor invitation only) Reviews are comprehensive analyses of specific topics that are solicited by the Editor. Proposals for reviews may be submitted via the online submission system as a pre-submission enquiry. PLEASE NOTE: All reviews should include search criteria and selection criteria in a Methods Section, along with the total number of articles identified and the total number selected for inclusion in the review. All invited reviews will undergo peer review prior to acceptance.	Unstructured abstract However, if your Review is systematic, please provide a structured abstract. 3–6 keywords	Abstract: 300 words Article: 6,000 words max excluding abstract, references, figures and tables.	Max of 8	Max of 120
Letters to the Editor Letters to the Editor will be considered for publication, subject to editing. Letters must contain information critical to a certain area or must be referencing data recently published in <i>IJO</i> . A Letter must reference the original source but can use an arbitrary title.	No abstract required.	500 words max excluding references, figures and tables.	Max of 2	Max of 10
Editorials (by Editor invitation only) Proposals for Editorials may be submitted; authors should only send an outline of the proposed paper for initial consideration.	No abstract required.	1,000 words excluding references, figures and tables.	Max of 2	Max of 10
Commentaries (by Editor invitation only) Commentaries discuss a paper published in a specific issue and should set the problems addressed by the paper in the wider context of the field.	No abstract required.	1,500 words excluding references, figures and tables.	Max of 1	Max of 10
Debates Debates address an area of research which is of major present interest, and for which there are substantially different views. Subject and authors are chosen by the editors but proposals are welcome.	Unstructured abstract 3–6 keywords	Abstract: 100 words Article: 2,000 words excluding references, figures and tables.	Max of 1	Max of 20
Technical Reports Technical Reports are original articles that address areas of more methodological interest. The content of these Reports must have direct relevance to the field of Obesity and have the same level of scientific rigour expected of the normal original articles.	Structured abstract 3–6 keywords	Abstract: 300 words Article: 2,500 words excluding references, figures and tables.	Max of 4	Max of 25

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QHR MANUSCRIPT GUIDELINES

SEPTEMBER, 2011

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- Note that the *corresponding author* completes and signs the form on behalf of all coauthors of a particular manuscript; it is not necessary to obtain the signature of each author. Remember that all author names must appear on the first page of the form. *Please print legibly!*
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JOURNAL STYLE

GENERAL INFORMATION

This section of the Guidelines covers matters of *QHR* journal style, which are not subject to author preference; adherence is required.

Note: If you still have questions after carefully reading these instructions, please refer to the sample manuscripts (there are several types) beginning on page 35 before contacting the *QHR* office.

IMPORTANT CONSIDERATIONS

- *Qualitative Health Research* is a peer-reviewed journal. Only complete, finished manuscripts should be submitted for consideration.
- We do not publish stand-alone abstracts, *quantitative* studies, manuscript outlines, pilot studies, manuscripts-in-progress, letters of inquiry, or literature reviews. Research articles *must be pertinent to health*.
- Write both the abstract and the text of your manuscript in *first-person, active voice*.
- For best results, review this entire document prior to preparing and submitting your manuscript.
- Proper manuscript preparation will speed the peer-review process for your manuscript, and will facilitate a smoother production process if it should be selected for publication.
- Improper manuscript preparation could result in burdensome revisions, lengthy delays in the review and production processes, and the possible rejection of your manuscript.

GENERAL STYLE

We ask authors considering submission to *QHR* to review these guidelines, survey several issues of the journal, and make their own decision regarding the "fit" of their article for *QHR*'s mission. *Please refrain from writing or calling to ask if we are interested in your particular manuscript or idea.*

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August 23, 2011

MANUSCRIPT PREPARATION

ELEMENTS OF A MANUSCRIPT

Note: Some instructions differ for *accepted* manuscripts; please refer to page 28.

The following elements are **required** for each manuscript, and should be compiled in the following order:

Title page	Submit the title page as a <i>separate document</i> .
Abstract	The abstract is placed on page 1 of the main document.
Keywords	Place the keywords below the abstract, on the same page. Leave a (double-spaced) blank line between the abstract and the keywords.
Main manuscript	The main text of the manuscript begins on page 2 of the main document.
References	References begin on a new page, after the end of the manuscript text, or after the notes, if any (<i>do not</i> submit references in a separate document).

The following elements are **optional**, and may be included in your submission:

Notes	Place notes (also known as endnotes) after the main text, before the first page of references.
Tables	Place tables, <i>one per page</i> , at the end of the main manuscript document, after the references (<u>do not submit tables as separate documents</u>).
Figures	Submit each figure in a <i>separate document</i> , in order, by number.
Appendices	Appendices are published <i>only at the editor's discretion</i> . Place any appendices after the reference list, and before any tables (place them before the bios in accepted manuscripts).

	Avoid phrases such as <i>We wish to thank</i> , <i>We would like to thank</i> , and <i>We want to thank</i> ; just use a simple, <i>We thank</i> , or <i>We acknowledge</i> .
Declaration of conflicting interests	<p>You must use one of the following statements, in the exact words shown below.</p> <p><i>If you have no conflicts of interest (or potential conflicts of interest):</i> The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.</p> <p><i>If you have conflicts of interest:</i> The author(s) declared the following potential conflicts of interest with respect to the research, authorship, and/or publication of this article: [Then, in sentence form, list all specific author relationships with organizations and/or products that were declared].</p>
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The abstract should be placed at the top of page 1 of the main manuscript document. It should be a single paragraph, no more than 150 words in length, and briefly describe your article. It should not contain headings or citations, and should not be divided into sections. Place your keywords below the abstract, on the same page (see "Keywords," above).

Double space the entire abstract page (including the keywords). Briefly state the purpose of your research, the main findings, and your primary conclusions. Make sure the abstract is written in the first-person, active voice.

MAIN MANUSCRIPT

Note that the sample manuscripts beginning on page 35 are abbreviated for illustration purposes, and might not contain all optional elements that could be included in an actual manuscript. The sample articles contain all four heading levels.

The main text of the manuscript begins at the top of page 2 of the document, immediately after the abstract page. *Write your article in the first-person, active voice.*

The main text of the manuscript should be broken into appropriate sections by the use of section headings. Sections should flow in a logical sequence, and include, at a minimum, *Methods*, *Results*, and *Discussion* (these are all level-1 headings); other level-1 headings and subheadings may be used at the author's discretion. The author may choose to use different names for the three main sections, but the basic content should be that which would appropriately fall under the headings of *Methods*, *Results*, and *Discussion*.

PREPARATION OF MANUSCRIPT ELEMENTS

A maximum of four (4) *types* of documents should be submitted: (a) title page; (b) main manuscript; (c) figures (if any); and (d) permissions (if needed). Despite what the online submission system (ScholarOne Manuscripts / SageTrack) might allow, *do not submit such elements as abstracts, references, and tables in separate documents*. Be sure to refer to the sample manuscripts, beginning on page 35.

TITLE PAGE

The title "page" may be longer than one page. To maintain author anonymity during peer review, it is submitted as a *separate document*. Title page information *should not be included* in the main manuscript document. *Do not format a running header*. The title page should include the following, *in this order*:

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Author names	<p>List the name (not just initials) of each author, <i>without credentials</i>, in order, horizontally across the page.</p> <p>If there are two authors, list them as follows: Janice M. Morse and Author Two</p> <p>If there are three or more authors, list them as follows: Janice M. Morse, Author N. Two, Writer Three, and Fourth Author (and so forth)</p> <p>After each name (or <i>after</i> the comma following a name, if applicable), use a superscript number to link that particular author with his or her <i>primary</i> affiliation (see the section on author affiliations, below).</p>
Author affiliations	<p>Using the same superscript numbers as used with the authors' names (see above), list <i>only the primary affiliation</i> of each author, not multiple affiliations (see the sample manuscripts).</p> <p>Spell out all city, state, and country names (exception: use USA instead of United States). Spell out any organization or institution names (for example, <i>University of Utah</i> instead of <i>U of UT</i>, or <i>World Health Organization</i> instead of <i>WHO</i>).</p>
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Acknowledgments	<p><i>This is optional.</i> The section is limited to two (2) or three (3) <i>brief</i> sentences. Overlong acknowledgments will be reduced at the copyeditor's discretion. Do not include long descriptions of persons being acknowledged, and do not include roles, titles, or credentials.</p>

APPENDIX B

Quality Checklist

Quantitative

Qu	Criteria	Present? Y/N
1	Does the title reflect the content?	
2	Are the authors credible?	
3	Does the abstract summarise the key components	
4	Is the rationale for undertaking the research clearly outlined?	
5	Is the literature review comprehensive and up-to-date?	
6	Is the aim of the research clearly stated?	
7	Are all ethical issues identified and addressed?	
8	Is the methodology identified and justified?	
9	Is the study design clearly identified, and is the rationale for choice of design evident?	
10	Is there an experimental hypothesis clearly stated? Are the key variables clearly defined?	
11	Is the population identified?	
12	Is the sample adequately described and reflective of the population?	
13	Is the method of data collection valid and reliable?	
14	Is the method of data analysis valid and reliable?	
15	Are the results presented in a way that is appropriate and clear?	
16	Is the discussion comprehensive?	
17	Are the results generalizable?	
18	Is the conclusion comprehensive?	
Total		

Max total = 18

High = 16 – 18

Med = 13 – 15

Low = <12

Qualitative

Qu	Criteria	Present? Y/N
1	Does the title reflect the content?	
2	Are the authors credible?	
3	Does the abstract summarise the key components	
4	Is the rationale for undertaking the research clearly outlined?	
5	Is the literature review comprehensive and up-to-date?	
6	Is the aim of the research clearly stated?	
7	Are all ethical issues identified and addressed?	
8	Is the methodology identified and justified?	
9	Are the philosophical background and study design identified and the rationale for choice of design evident?	
10	Are the major concepts identified?	
11	Is the context of the study outlined?	
12	Is the selection of participants described and the sampling method identified?	
13	Is the method of data collection auditable?	
14	Is the method of data analysis credible and confirmable?	
15	Are the results presented in a way that is appropriate and clear?	
16	Is the discussion comprehensive?	
17	Are the results generalizable?	
18	Is the conclusion comprehensive?	
Total		

APPENDIX C

Participant Information Sheets Parent/Guardian & Young Person

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF
WARWICK



Participant Information Sheet Parents/Guardians

'Understanding Weight-Related Views and Experiences of Young People.'

Your child is being invited to take part in a research study. Before you decide if your child can participate, it is important to understand why the research is being done and what it will involve. Please read the following information carefully. Please ask if there is anything that is not clear or if you would like more information.

Thank you for reading this.

What is the purpose of the study?

There is little research that has specifically asked for the views of young people directly for their ideas and beliefs around weight and what they feel could help a person to achieve a healthy weight. The aim is to therefore speak to young people to find out their ideas and opinions. It is hoped that these findings would contribute to what might be included in future programmes that aim to support young people with their weight.

Why has your child been chosen?

Young people who are receiving a service from a weight management programme are being asked to take part in the study.

Does he/she have to take part?

Your child does not have to take part in this study, it is up to you to decide. If you do give consent for your child to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide that your child can take part but later change your mind, you can withdraw your child from the study without giving a reason. You would have two weeks from the date of recorded conversation to withdraw your child's information from the study. Once you have consented, then your child will be asked if they would like to take part.

Parent/Guardian Information Sheet

Version 3

3.04.2013

Dean of Faculty of Health and Life Sciences

Dr Linda Merriman MPhil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Head of Department of Psychology

Professor James Tresilian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

www.coventry.ac.uk

Whether or not you decide that your child can take part in this study, this will not affect the service that you are receiving from the weight management programme.

What would he/she have to do if they did take part?

The research simply requires a one-off conversation with your child, where he/she will be asked to talk about experiences related to weight. The topics for discussion will broadly be around views on their own weight and ideas on what may help them to achieve a healthy weight.

This conversation will be tape recorded. The length of this is estimated to last for about 1 hour, but the length of time depends on how much they have to say.

Where possible, the discussion can be held after the group meeting at these premises or at the offices of the weight management programme. If this isn't possible, we can meet at your home or a location convenient for you. The discussion would be one-to-one but it would be expected that you or staff would be available, and that we would be visible at all times. However, if you or your child felt more comfortable for you to sit in on the discussion then this can also be arranged.

The researcher has a recent enhanced Criminal Records Bureau (CRB) check.

What are the possible benefits of taking part in this study?

A £5 High Street voucher is offered to your child, after gaining your consent on whether or not this can be offered. This is a gesture to thank your child for giving their time.

Aside from this, there may not be any other benefits for your child directly, other than to have their views and experiences heard. However, it is hoped that this study may inform future service provision to help other young people.

What about confidentiality and anonymity?

All information that is collected about your child will be kept strictly confidential. A written copy of the recording will be made and then the recording will be destroyed. The information about your child will be kept completely anonymous as no names will be recorded on the written copies, instead a participant number will be given. These written copies will be kept in a locked filing cabinet at Coventry University, only the researcher will have access to them. These written copies will be stored for 5 years, in accordance to the Data Protection Act.

The only reason that there could be a breach of confidentiality is if the researcher is concerned about a person's risk of harm, either to themselves or to others. In these circumstances the researcher would need to share this information with her supervisory team and other professionals. This is in line with the NHS policy on confidentiality.

What if something goes wrong?

In the unlikely event that your child becomes upset by taking part in this research, you can withdraw your child from the discussion. You can also speak with staff at the weight management programme, the school nurse or access websites such as Childline on 0800 1111 or at www.childline.org.uk for further support should you need it.

What if there is a problem?

If you are concerned about any aspect of this study please speak to Nikala Kumari (researcher) or Jacky Knibbs (project supervisor). If you remain unhappy and wish to complain formally you can do this through the NHS complaints procedure. Details regarding this process can be obtained from the Patient Advice and Liaison Service (PALS) on www.pals.nhs.uk.

What will happen to the results?

The results of this study will be written up as part of the researcher's Doctoral thesis. The results will involve identifying themes across all of the discussions, and quotes may be used as examples of each theme. However, no individual participant would be identifiable from these quotes as no names or any other identifying information would be used.

Should you be interested in having a summary of the findings once the study is over, the researcher will ask for some contact details in order to send this information.

Who has reviewed this study?

The research has been approved by the NHS Ethics Committee as well as the University Research Ethics Committee, Coventry University.

Who can I contact for further information about this study?

You can contact the researcher if you have any queries about this study:

Nikala Kumari

Clinical Psychology Doctorate
James Starley Building
Coventry University
Priory Street
Coventry , CV1 5FB

email: kumarin@uni.coventry.ac.uk
Telephone: 0204 76 888714

Thank you for taking the time to consider this research

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D., CPsychol

THE UNIVERSITY OF
WARWICK



Participant Information Sheet
Young Person

'Understanding Weight-Related Views and Experiences of Young People.'

I am asking if you would like to join in a research project to give your views and opinions on the issue of weight. Before you decide if you want to join in, it's important to understand why the research is being done and what it will involve for you. So please consider this leaflet carefully. Talk to your family, friends, or the staff on the weight management programme if you want to.

Why are you doing this research?

I am doing this research because not very many studies have asked young people like you about your experiences, and listened to your ideas on what you think you might need to make any changes. I thought that it would be good to get your ideas and opinions as this may help to design new weight management programmes in the future.

Why have I been invited to take part?

Anyone who is attending a weight management programme like this group, who is aged between 11-13 years old, is being invited to take part.

Do I have to take part?

No. It is up to you. I will ask if you want to be in the research and then ask you to sign a form if you decide you want to take part. I will give you a copy of this information sheet and the form you signed that states that you would like to take part for you to keep. You are free to stop taking part at any time during the conversation without giving a reason. If you decide that you don't want me to use the information you give me, you will have 2 weeks after we have met to let me know.

If you do decide to stop, this will not affect the care you receive from your weight management programme.

Young Person Information Sheet

Version 2

3.04.13

Dean of Faculty of Health and Life Sciences

Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Head of Department of Psychology

Professor James Tresilian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

www.coventry.ac.uk

What will happen to me if I take part?

We would meet to talk for about an hour. I will tape our discussion so that I can talk to you properly and not have to make notes.

I would like to ask you some questions to find out things like what you think about other people's weight as well as your own, if you have wanted to lose weight, and if so what sorts of things you have found helpful or unhelpful about trying to lose weight.

Is there anything to be worried about if I take part?

I appreciate that this might be a sensitive topic for some people. There might be times where you feel embarrassed or self-conscious. If you do then you can choose to answer questions or not. If you like, you can take a break or stop the discussion. If you feel more comfortable, you can invite your parent / guardian in to the discussion too.

If you want to talk more, after we have met, you could try the school nurse, your GP or websites such as Childline on 0800 1111 or at www.childline.org.uk

How will this help me?

I cannot promise that this study will help you directly, but the information that I get might help to improve future weight management programmes for young people like this one.

Will anyone else know I'm doing this?

I will keep your information in confidence. This means I will only tell those who have a need or right to know.

I will only need to share information about you if you told me something that made me concerned about your safety. If I was worried about you, then I would talk to my supervisor about my concerns. I would discuss this with you beforehand however.

What will happen to the information that I give you?

I will write down our discussion so that I have a record, but will keep both the recording and written record in a locked cabinet to ensure that no one else will be able to have access to your information. Also, I will not put your name on any of the information.

Who has reviewed the study?

Before any research goes ahead it has to be checked by a Research Ethics Committee. They make sure that the research is fair. This project has been checked by the NHS Ethics Committee as well as the University Research Ethics Committee, Coventry University.

Who can I contact if I want more information?

Here are my contact details if you have any further questions:

Nikala Kumari Email: kumarin@uni.coventry.ac.uk

Telephone: 024 76 888714

Thank you for reading this – please ask any questions if you need to

APPENDIX D

REGISTRY RESEARCH UNIT ETHICS REVIEW FEEDBACK FORM

(Review feedback should be completed within 10 working days)

Name of applicant: Nikala Kumari.....

Faculty/School/Department: [Health and Life Sciences] HLS Clinical Psychology

Research project title: 'Understanding Weight-Related Views and Experiences of Young People'

1. Evaluation of the ethics of the proposal:

I am happy that all relevant ethical issues have been considered and ways in which risks will be mitigated have been explained.

2. Evaluation of the participant information sheet and consent form:

These are comprehensive and age appropriate.

3. Recommendation:

(Please indicate as appropriate and advise on any conditions. If there any conditions, the applicant will be required to resubmit his/her application and this will be sent to the same reviewer).

<input checked="checked" type="checkbox"/>	Approved - no conditions attached
<input type="checkbox"/>	Approved with minor conditions (no need to re-submit)
<input type="checkbox"/>	Conditional upon the following – please use additional sheets if necessary (please re-submit application)
<input type="checkbox"/>	Rejected for the following reason(s) – please use other side if necessary
<input type="checkbox"/>	Not required

Name of reviewer: Anonymous

Date: 25/01/2013

25 April 2013

Miss Nikala Kumari
Department of Clinical Psychology
James Starley Building
Priory Street,
Coventry
CV1 5FB

Dear Miss Kumari,

Study title:	Understanding Weight-Related Views and Experiences of Young People who are Overweight
REC reference:	13/WM/0112
IRAS project ID:	121048

Thank you for your letter of 17 April 2013, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Rebecca Morledge, NRESCommittee.WestMidlands-Edgbaston@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Evidence of insurance or indemnity		01 August 2012
Interview Schedules/Topic Guides	1	17 December 2012
Investigator CV	Miss Nikala Kumari	17 December 2012
Investigator CV	Jacky Knibbs	14 December 2012
Investigator CV	Fiona Jane Maccaalum	
Letter from Sponsor		21 February 2013
Other: Coventry University Ethics Review Feedback Form		25 January 2013
Participant Consent Form: Parents/Guardians	1	17 December 2012
Participant Consent Form: Young Persons	1	17 December 2012
Participant Consent Form: Parent/Guardian	2	03 April 2013
Participant Consent Form: Assent Form - Young Person	2	03 April 2013
Participant Information Sheet: Parents/Guardians	2	18 January 2013
Participant Information Sheet: Young Persons	1	17 December 2012
Participant Information Sheet: Parents/Guardians	3	03 April 2013
Participant Information Sheet: Young Person	2	03 April 2013
Protocol	2	17 December 2012
REC application	121048/413318/1/117	12 February 2013
Response to Request for Further Information		17 April 2013

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

13/WM/0112

Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely,

A handwritten signature in black ink, appearing to be 'PP' followed by a stylized flourish.

Mr Paul Hamilton
Chair

Email: NRESCommittee.WestMidlands-Edgbaston@nhs.net

Enclosures: "After ethical review – guidance for researchers" [SL-AR2]

Copy to: BBC CLRN RM&G Consortium

APPENDIX E

Consent / Assent Forms

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Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
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THE UNIVERSITY OF
WARWICK



Patient Identification Number for this trial:

CONSENT FORM – Parent/Guardian

Title of Project: 'Understanding Weight-Related Views and Experiences of Young People.'

Name of Researcher: **Nikala Kumari**

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated **(3.04.13; version 3)** for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my child's participation is voluntary and that he/she is free to withdraw at any time without giving any reason, without his/her medical care or legal rights being affected. ☐
3. I agree for the interview to be tape recorded. ☐
4. I understand that the anonymised data collected during the study, may be looked at by individuals from the Coventry & Warwickshire training course, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐
5. I would like to receive a written summary of the findings from this study. I am happy to provide contact information in order to receive this. ☐

Consent form date of issue: **3.04.13**
Consent form version number: **Version 2**

Page 1 of 1

Dean of Faculty of Health and Life Sciences
Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805
Head of Department of Psychology
Professor James Tresilian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

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6. I agree for my child to take part in the above study.



_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person	Date	Signature taking consent.

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
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Programme Director
Doctorate Course in Clinical Psychology
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THE UNIVERSITY OF
WARWICK



Patient Identification Number for this trial:

ASSENT FORM – Young Person

Title of Project: 'Understanding Weight-Related Views and Experiences of Young People.'

Name of Researcher: Nikala Kumari

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated **(3.04.13; version 2)** for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that I don't have to take part if I don't want to.

☐

3. I agree for the discussion to be tape recorded.

☐

4. I agree to take part in the above study.

☐

Name of Participant

Date

Signature

Name of Person
taking consent.

Date

Signature

Consent form date of issue: **3.04.13**
Consent form version number: **version 2**

Page 1 of 1

Dean of Faculty of Health and Life Sciences

Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Head of Department of Psychology

Professor James Tresilian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

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APPENDIX F

Interview Schedule

Overall themes with prompts:

Introduction: General information about participant.

- Age/ethnicity/religion
- Family life, who lives at home with you?

Views on their own weight status

- How do you feel about your weight?
- Any previous attempts to lose weight in the past? Experiences of this.
- Other people's opinions on your weight or health in general? What do you make of this?

Significant others views on shape/weight/exercise/eating

- Who is important in your life? Who would you seek advice from / seek opinions from?
- What are their views on body size and weight?
- What are their views on exercise?
- What are other people's views on your shape/weight/eating habits/exercise?

Views on what you / someone with overweight might need in place to help achieve a healthy weight.

- What have you found helpful or unhelpful in the past?
- Who has been helpful (parents, teachers, friends, GP etc)
- Working on losing weight individually or in groups?
- Any barriers to making changes (feeling self-conscious, not wanting to do physical activity, not knowing how, psychological factors such as feeling nice when eating etc)

APPENDIX G

Example of Coding

FOCUSED CODE

LINE-BY-LINE

gotta...and then it just costs too much, like it'll probably cost you about £20 but £30 a week...just to do it

I: oh so it's really expensive?

P2: like, milkshakes are about 2-3 pound each.

I: oh god, ok. So your mom was funding that?

P2: yeh!

I: ok, what do you think your mom thinks about your weight?

P2: she, like...she won't call me fat, she'll just say that I need to lose weight...but she knows that I know that. And she knows she's a bit overweight herself, but she's not like massively obese. But then, my step dad encourages her 'cos he's really skinny so she's got him to support her and I've got my mate.

I: so it sounds like you've recognised that if you've got somebody to support you...it's easier)...that that can be helpful. Do you always feel like you've been supported or were there times when you didn't feel supported?

P2: yeh because like, I've known my mate since primary school so she's always been there. But in primary school you weren't as conscious about it because kids weren't as bad like that, but as soon as it hit the secondary school then it got 10 times worse 'cos, well year 5 year 6 it gets bad, but when you go into secondary school it just gets really really bad because of how hard they think they are and all this and that and then they just don't think about ya.

I: so have you had teachers involved at all?

Avoid the word 'fat'

Awareness of self + child size.

Getting support to lose weight

Self-conscious

Being overweight got harder over the years.

Fell up being bullied.

- known mate along time. - close friend.

- primary school 'one' is not self-conscious. - she's always been there.

- hit secondary school, gets worse. - kids weren't as bad then.

- well, primary school gets bad. - move to secondary school really hard.

- kids think they're hard. - kids don't think about you.

- they don't think about me.

FOCUSED CODE

LINE-BY-LINE

hard teachers involvement
doesn't help *doesn't have an impact*
teachers just carry on
 P2: I've had teachers involved once or twice but it doesn't stop and they just carry on
teachers don't expect you to tell *and you don't go back to teachers*
 but they don't expect you to go tell the teachers again cos you won't, cos you...the
teachers say things - make you feel scared *that they're gonna actually do something*
 things they say to you, you get scared that they're gonna actually do something.

I: oh ok, that sounds quite tricky really doesn't it?

P2: yeh

I: how do you think all of those experiences have affected you?

confidence knocked *but, I need to rebuild it* *and I can do that*
 P2: it's knocked my confidence a lot. But, I've tried to rebuild my confidence and I can
things I've done make you feel good *people praise me* *gives me confidence*
 because of things I've done like, people praise me and things so it gives you more
teachers come back and knock you down *get yourself back up*
 confidence but then, they come back and knock you down, but then you get back up.
it's not so bad
 So, it's not as bad.

I: wow. So you know that it's knocked your confidence...in what areas has it knocked your confidence do you think?

feel more paranoid *sports day*
 P2: as I said before, it makes you more paranoid. You don't feel like, say for sports day
don't want to do it
 for instance, you don't wanna do any of the races cos it makes you think that
notice others
 everyone's gonna be talking about you while you're doing the race, or while you're
everyone's noticing
 walking around in the playground I think that someone's gonna start sayin something
about me
 about you because you're apparently really fat or something like that...or you...cos
you'll suddenly become obese
 you're eating...say you're eating a chocolate bar, I will suddenly become like obese, and
 all this.

I: so other people's comments have definitely knocked your confidence and made you feel a bit more paranoid about eating and about doing exercise.

P2: yeh

I: do you remember becoming aware of your body and maybe thinking that you weren't

happy with your body shape or anything?

Self-consciousness increased with time. always been self-conscious of body. since year 3/4. P2: I suppose I've always been like conscious of my body since I was in like, year 3 - since I was very young. it's got worse over the years.

I: so as the years have gone on you've found you felt more and more self-conscious

about it.

P2: yeh

I: ok, so what do you think your family thinks about their relationship with food?

family members relationship with food. P2: well, my sisters like a really fussy eater. But my mom, she eats whatever, like I do. Like, we eat quite a lot of things, we don't have...some of us have quite a bit but sometimes we don't and sometimes we can go without food and sometimes we don't. But my dad's side of the family eat...they're quite bulky like, they're a bit...obese because they do eat quite a lot. But then my Nan's started stop eating but...she's eating less so that she's still gonna put on the weight. So it's kind of complicated!

I: ok, so what's your Nan doing sorry?!

family struggling to make changes. P2: like...for instance, like instead of having her regular meals, she'll probably just have breakfast biscuits in the morning, and then in the afternoon she'll have lunch and breakfast...lunch and tea at the same time, so she'll have twice as much for tea which doesn't help. And then she's eating later on in the night.

I: and what are your thoughts on that?

layed back family struggling to change. P2: I think she's got to a stage where she's struggling to change but I don't think...I'm not ashamed of Nan. Nan is overweight. Overweight for her. Nan so I don't care what people say.

I: ok. So you mentioned this idea about struggling to make changes. Do you think

there's anything in particular that might make it hard to make changes?

Breaking
when they
is hard.

P2: you get used to the same old cycle so you're in a special routine, so like, cos you
- as soon as you don't have breakfast, you've got to get used to not having it
- need to fit in meals with routine, getting ready to go out
having it and fitting it in with getting ready for school, getting ready to go places, and
- not used to having breakfast, but have massive lunch
then if you're used to not having breakfast then suddenly having a massive lunch, then
- long gap until dinner, getting into some cycles
leaving it til about 9 o'clock to have tea, you're getting in the same cycle so it's harder - harder is one
- have all 3 meals at 'normal' times, breakfast - to
to have breakfast, then have lunch and then have tea, but all in the normal time. So it gets harder.
- gets harder.

I: so the idea about changing routine makes it more difficult...

Struggle to
change routine
to incorporate
eating + exercise.

P2: yeh and then trying to fit exercise in at the same time makes it harder as well. - makes it hard.

I: hmmm...and what are your views on exercise? Are you a family that are interested in

exercise or...

Important
to find
exercise
that interests
you.

P2: we're all interested in it, it's just...if it's an exercise you don't like, you don't wanna
- all interested in exercise, but if you don't like an exercise
do it so you don't put effort in. So like, I can go on the trampoline for 3-4 hours straight
- I can go on the trampoline as long as I like
without worrying but, if it was like, having to do a jog or run around a field for an hour I
- I wouldn't, I'd walk.
just wouldn't bother, I'd just walk!

I: (laughs).

P2: you know what I mean! I like bike riding, swimming, basketball, trampolining...we
- like those activities
like loads of sports we just...half of them we actually do but some we don't even enjoy
- half of those activities we do, but some don't
so we just don't bother with them. enjoy.

APPENDIX H

Example of the Constant Comparative Method

This is an early example of how I carried out the constant comparative method (Glaser and Strauss, 1967) showing the similarities from two different interviews that led to the development of a focused code in the analytic process.

Reflective Journal extract after interviewing Participant 5 (P5)

He did say about *previous dieting* though, and that he used fasting as a sort of cover for actually *restricting*. He only did it once, and for one day and then he got too hungry. But it sort of reminded me of the classic cycle where people set unrealistic rules for themselves, feel like a failure for not being able to stick to them and then *overeate*. It struck me that he was describing the beginnings, or the mind set of this mentality really and that was such a shame, he's only 11!

Reflective Journal extract after interviewing Participant 10 (P10)

She mentioned her *previous dieting* experiences and basically just *restricted* her food intake, and she was really young at the time. She wanted to come to a weight management programme though because, after that period of restricting, she went on to *overeate* and put all that weight back on. It was really difficult for her though, but she seems more determined to do things a little more healthily now that she's got some information on how to go about things. Made me think back to P5 and his attempt to *restrict*. What was most striking was that they both took it upon themselves to do that, and it was just *really hard* going.

APPENDIX I

Table demonstrating the development of focused coding through to the final conceptual categories.

Conceptual Categories	Axial Codes	Focused Coding examples
Sense of self	Identity	<ul style="list-style-type: none"> - Acknowledging my size - Impact of feedback from others - The group: do I fit in? - 'I'm active'
	Body Image	<ul style="list-style-type: none"> - Ideal body - Impact of being self-conscious
Making sense of being overweight	The physical Impact of being overweight	<ul style="list-style-type: none"> - Consequences to the body - Ability to exercise - Future worries
	Emotional eating	<ul style="list-style-type: none"> - Eating as a coping strategy
	Responsibility for diet	<ul style="list-style-type: none"> - Taking control - Parents in control - Out of control
Managing being overweight	The importance of education and knowledge	<ul style="list-style-type: none"> - Getting specific facts - Education for the family
	The role of support in making changes	<ul style="list-style-type: none"> - Practical support - Parental intervention - Exercising with others
	The dieting journey	<ul style="list-style-type: none"> - Dietary changes - Changing routine - Barriers to change
	Personal characteristics	<ul style="list-style-type: none"> - Motivated to lose weight - Gaining new skills
Systemic context	Family identity	<ul style="list-style-type: none"> - Family and dieting - Family and healthy living
	Peers and teasing	<ul style="list-style-type: none"> - Being teased about shape and size - Emotional impact of teasing - Concern about being judged - 'fighting back' against bullies
	The influence of the media	<ul style="list-style-type: none"> - Portrayal of body size - Portrayal of emotional eating